

# HARVARD MEDICAL ALUMNI BULLETIN

Summer, 1966



# LETTERS

## Double Trouble

To the Editor:

With respect to the letter from Dr. Alan Butler in the most recent issue of the *Bulletin*, I would like to ask, as a gynecologist, whether there is any other operation in surgery other than hysterectomy which is unnecessary. It seems to me that the "unnecessary hysterectomy" has been beaten to death. Perhaps if Dr. Butler were to speak of unnecessary pediatric procedures, he might be on firmer ground.

Incidentally, "tonsillectomy" is spelled with two l's.

BRUCE A. HARRIS, JR. '43A  
Huntington, N.Y.

*Note:* Dr. Harris is right, "tonsillectomy" has two l's not one, but we note that Dr. Butler spells his name with two too—Allan.—ED.

## A Challenge Given ... and Accepted

To the Editor:

In the Spring issue of the HMAB there is an editorial, "The Thing About Yaws," by Robert M. Goldwyn '56.

With almost all of this editorial I can agree but with one statement I must take issue—as I am sure many others do.

Dr. Goldwyn is reported to have said, "Despite the engagement of our nation in the use of gas, herbicides, and, as recently reported, torture, the medical profession has shown remarkably little concern."

In this sentence Dr. Goldwyn appears to state that the armed forces of the United States have used poison gas and have indulged in the practice of torturing prisoners. Dr. Goldwyn is misinformed and is repeating pro-Communist propaganda. I would challenge him to produce details of either charge with dates, places, etc. In making such unwarranted charges he is denigrating our armed forces and our Nation—thus indirectly

aiding our enemies at a critical stage in our history.

We have employed no real poison gas in Vietnam—only tear gas which is used by police forces all over the world. This is not classed as a "poison" gas.

As to torture, no branch of our armed forces has advocated or condoned it. I have been in the military service in two World Wars and it is well known that in all wars there are individual instances of mistreatment of prisoners of war on both sides. Any military man familiar with what has happened in Vietnam recently will testify that our treatment of Viet Cong prisoners is far more humane than the treatment given our men (especially aviators) who have been captured by the Viet Cong or the North Vietnamese. It is well known that North Vietnam has refused to cooperate with the International Red Cross and to allow inspection of camps for prisoners-of-war.

Congratulations on putting out an excellent *Alumni Bulletin*.

FRANCIS TWINEM '25  
New York, New York

The *Bulletin* referred Dr. Twinem's letter to Dr. Goldwyn, who offers the following reply:

To the Editor:

Dr. Twinem correctly quoted me saying that our nation had employed "gas." I did *not* state that it was *poison* gas. However, the supposedly non-lethal gases have resulted in the hospitalization of several soldiers and the death of at least one, an Australian (Brisbane, *Courier-Mail*, Jan. 13, 1966). Unfortunately, we have been responsible for instances of brutality apart from what has usually been considered normal conduct of war. Electrical torture, psychological torture, and "the long step"—pushing a prisoner out of a helicopter are a few of the methods used. *Nation*, Dec. 21, 1964 and Oct. 25, 1965; *New York Herald Tribune*, Apr. 25, 1965; *The New York Times*, July 7, 1965; *Liberation*, Feb., 1966; *The New Face of War* by Malcolm Browne, Bobbs-Merrill Co., 1965.

*The New York Times* stated on Dec. 1, 1965, "The International Committee of the Red Cross in Geneva . . . complained again that the United States was violating an international accord on the treatment of prisoners." A former Red Cross Executive said: "The Viet Cong fighters are as protected by the Geneva Conventions as the American G.I.'s are. Dramatic protests against violations of the Geneva Conventions should have been made when the first Viet Cong prisoners were shot, when they were tortured, when the American Army started to destroy Viet Cong Hospitals and to cut off medical supply . . ." (*The New York Times*, International Edition, Oct. 14, 1965).

Even if we assume that the enemy has engaged in torture more than we, it seems inappropriate for a physician to condone these practices when his own country employs them. At the risk of "aiding our enemies," as Dr. Twinem fears, we must speak out against the gross dehumanization that the expediencies of war create. It is, after all, supposedly in pursuit of human dignity that we have gone to war.

ROBERT M. GOLDWYN '56  
Brookline, Mass.

## Do HMS Students Need SAMA?

To the Editor:

Senator William Fulbright once said, "Criticism is more than a right, it is a patriotic duty." In four years at the Harvard Medical School, I have heard very few students offer informed, constructive criticism of activities of the Government or the AMA which affect medical teaching, practice and research. Students have rarely discussed and have never publicly debated state and national legislation regarding contraception, abortion, health insurance, narcotics addiction, drug testing or medical

*Continued on page 58.*

# HARVARD MEDICAL ALUMNI BULLETIN

Vol. 40      Summer, 1966      No. 5

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**COVER:** This Alumni Day issue is presented with the idea that "to renew ties with the past need not always be daydreaming; it may be tapping old sources of strength for new tasks." (Simeon Strunsky, *No Mean City*, 1944.)

LETTERS . . . . . II

ALUMNI DAY . . . . . 2

MORNING PROGRAM: *A Time of Change by Langdon Parsons* . . . . . 4

Long Shots and Sure Bets by *Perry J. Culver* . . . . . 6

Student Problems and Profiles by *Joseph W. Gardella* . . . . . 9

A Faculty View of the Curriculum by *Howard H. Hiatt* . . . . . 11

The World, the Flesh and the Harvard Man by *Carl E. Taylor* . . . . . 13

AFTERNOON SYMPOSIUM: A Round Table Discussion on, "The Heart Disease, Cancer and Stroke Program." Moderator: Dean Robert H. Ebert, Panelists: Prof., Jerome Pollack, Drs., Lamar Soutter, Osler L. Peterson, Claude E. Welch, John H. Knowles and Mr. Henry C. Meadow . . . . . 17

REUNIONS . . . . . 24

CLASS DAY . . . . . 30

Windrows and Wrack by *George E. Gifford, Jr.* . . . . . 36

Speeches We've Heard Before, or the Overdone Cliché by *John R. Brooks* 42

ALONG THE PERIMETER: 1966 Appointments; Countway Library Award; HMAA Elections; Appointments at Cambridge City Hospital; Dr. Rabkin Heads Beth Israel Hospital; Dr. Rutstein Receives Medal; Three HMS Alumni Embark on Deanships; Schizophrenia; Dr. Diamond Receives Kennedy Award; Mechanical Failure Factor in Auto Fatalities; New Building for Beth Israel Hospital; Joslin Award to Dr. Arky; Countway Library Computerized; Aesculapian Room Dedicated. . . . . 43

ALUMNI NOTES . . . . . 50

FACULTY NOTES . . . . . 57

OBITUARIES . . . . . 59

CREDITS: Photographs: W. H. Tobey, 2-7, 9, 11, 13, 17, 21, 30-35; Fay Photos, 24, 26-29; Bradford F. Herzog, 44, 49; Allen Morgan, 36, 38-40; Courtesy of Francis Wade (Dr. Townsend) 37. Drawings by Raymond Crane: Cover, 10, 12, 42, 51.

*The opinions of contributors to the Bulletin do not necessarily reflect those of the Editorial Staff.*

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Eleven-hundred Alumni returned on  
and heard the

# A Time of Change

by Langdon Parsons '27  
Director of Alumni Relations

**THIS IS THE FIRST ALUMNI REUNION** to be held in the courtyard of the new Countway Library. To me this is a thrilling setting which cannot help but fill you with pride. In a sense you helped create it, for the Alumni contributed over \$4 million to the Program for Harvard Medicine. On behalf of the Dean and the Faculty it is my privilege to welcome you back to your new home.

It is fortunate that you came at this time for it is a time of change, and I suspect that many of the landmarks you look on with so much nostalgia today will not be here five years from now. Reunions then will present more problems than they do today. It is bad enough to try to recognize your classmates without having to struggle to identify any of the old buildings you knew so well. It may also be a trifle difficult for you to recall the names of the Professors for twenty-six new ones have been added, largely due to the success of the Program. If you rack your brain you will remember that not many years ago the Harvard Medical School set out to raise 58 million dollars and believe it or not they did it. Some of you who are still making good on your pledges probably do remember the Program. It must be a source of great satisfaction to make these payments for you can see the changing face of the School and the smiles of the faces of the faculty who, thanks to the Program, can now concentrate on the problems of medicine rather than the grocer.

These are exciting times around Harvard Medical School. Stimulated by the foresight and energy of Dean Berry, you and other friends of the School have provided the tools to work with. It is up to us to use them to the best advantage. Lord knows we need the tools for the problems of medical education today are manifold. You are well aware that medical knowledge is expanding at a rather terrifying rate. Furthermore, the calibre of the student body continues to keep pace with the expansion. For example, one hundred of this year's graduating class entered the medical school with cum laude or higher degrees.

How are we going to teach these men? Should we expose them to all aspects of the expanding medical experience? How much free time should we allow the student in the curriculum? Should this time be spent in exploring subjects in depth or simply in trying to digest what he has been exposed to? Should there be more than one category of medical student: one primarily interested in the science of medicine; the other in the clinical aspects? Finally how are we going to translate what we now know and will continue to discover into practical application at the patient level?

These are but a few of the problems the Dean and the Faculty are going to be called on to meet. The gauntlet has been thrown. It is up to us to pick it up and develop a workable solution.

If these were the only problems the Dean had to settle his life would be complex enough but there are other more far reaching challenges. What should the relation of the Medical School be to the teaching hospital and the community? We can no longer pursue a policy of splendid isolation. We have an obligation to the community hospital as well as the teaching hospital. We have a similar obligation to the Community. How are we going to help to improve the medical care wherever it is needed?

At Alumni Day breakfast, Dr. Parsons



May 27, 1966

following speakers

during the

Morning Program

and Dean Ebert share a joke.



Dean Ebert is busily engaged in seeking the answers to some of these problems. Basically he is striving for excellence. He would then like to see it spread upon the waters so that the patient is at least touched by the ripple. These are tough problems.

There is another thing that Dean Ebert is anxious to do and that is to establish a closer relationship with Alumni. He needs you, and you need him. One way he can do this is by keeping you informed about some of the ideas that are being formulated here at the School to meet the challenges as heaved at it.

Perhaps the best way of keeping you up-to-date on the contemplated changes is to explain why the changes are necessary through the medium of the *Harvard Medical Alumni Bulletin*. It is not so much a "who dunit" periodical as a "why we dunit, or why we are thinking about doing it."

It is in this spirit that the present Alumni Day program is organized. You can hardly understand why things are done the way they are unless you understand some of the problems that have to do with either the admission of students, their problems as they try to adapt to a medical existence, or why curriculum changes are contemplated.

This preamble sets the stage to explain why your contributions to the Alumni Fund are so important. In the past you have supported the Annual Giving effort nobly, but largely through nostalgia and loyalty to the School. Much of it follows a pattern—"This is what I gave last year, so I will do the same thing this year." I wish I could encourage the Alumni to make the Annual Giving a thoughtful rather than an automatic process. We need your support for the scholarship program. It is also true that the School needs unrestricted money to work with. You may ask, "why do you need money if you already have a large endowment and have just completed a successful fund raising effort to the tune of 58 million dollars?" The problem is simply this: it costs more to run the Medical School. The experience at Harvard University points this up. One year ago it was announced that the endowment at Harvard exceeded one billion dollars. Yet the income provided only 21 per cent of the cost of running the University as against 35 per cent a few years ago when the endowment was much less. The expenses had risen from ten million to over 110 million dollars per year. A small but important part of this increase in cost can be traced to the need to support the students who come from low income groups. One third of the College entering class come from families whose average income is \$8,500. They simply have to have scholarship support.

We are no different here and the need is greater, for a medical education costs more. The average cost for a single student is now \$3,900 per year. Added to the debt he has already accumulated in college and contemplating the years of residency training ahead, the college student may think twice before he chooses a medical career. We cannot afford to let medicine become a rich man's game.

Harvard Medical School does very well by the student who has a financial problem: Approximately ten per cent of the class come from families with an income of \$6,000 or less. If the family with a \$10,000 dollar income has more than one child to educate it is equally hard put. As the cost of medical education and ordinary living rises, the financial demands on the student are almost insurmountable, unless he receives help. We promise the student nothing to come to Harvard Medical School but we do agree that he will not be allowed to drop out for financial reasons. Furthermore, we will not allow him to accumulate a debt of more than four thousand dollars during his time in school. This takes some nice juggling between scholarships and loans to meet the need. It also takes a lot of money. Last year the School paid out \$209,000 in loans, \$307,000 in scholarships and \$108,000 in fellowships.

Nearly two-thirds of the class require some financial help. The Government loan program provides for only \$2,000 per year, which is about one-half the actual need. You and I could go out and earn money by outside employment, but the curriculum nowadays is so time consuming that this is no longer possible. If we are to have a strong student body we must have a Scholarship Program to take care of the students who really need financial help.

I do not think all of you realize the part you play in maintaining the Scholarship Program. If you did, I suspect that the Annual Giving program would increase each year as the need increased. At present we provide a little more than one-half the amount required. The average Gift to the Fund is less than fifty dollars a year, but I have dreams of grandeur and think how wonderful it would be if all Alumni would simply make their contribution one hundred instead of fifty dollars.

No one wants to tell you what you should give, but I hope that the better you understand the need, the greater will be your response.

# Long Shots and Sure bets

by

Perry J. Culver '41

Assistant Dean for Admission

IT IS a great pleasure to be here this morning wearing both the hat of a member of the 25th reunion class and also a member of the Dean's Office. I came upon the idea for the title of this talk while visiting California last March. I gave a couple of medical lectures and attended the races at Santa Anita where I won a total of 60¢ by betting across the board on an absolute sure bet. I suddenly realized that sometimes long shots paid off much better.

The selection of medical students is somewhat akin to picking winners among racehorses. In both cases, we not only need to know that there is native ability, but also that there has been evidence of previous success. Even then, we never know for sure whether an individual will come out on top at a given time. In both instances, there are the obvious sure bets who ought to win hands down, and there are the long shots who surprise everyone. The presence of both is what makes for an interesting horserace.

That old handicapper, Dr. Worth Hale, a Nebraska cowboy in his youth, probably knew horse flesh well. He also had an uncanny ability to pick men. Beginning in 1918 and for twenty-three years thereafter, he almost singlehandedly selected the students who attended the Harvard Medical School. During the latter part of his tenure he had the assistance of a small committee on admission, but it was his decision which frequently turned a boy into or away from the Medical School doors. When we look at the list of prominent medical men who graduated from the Medical School during his tenure as Dean of

Admission, it is obvious that Worth Hale was unusually successful in picking winners. He seemed to understand the virtues as well as the shortcomings of individual applicants. The high standards which he helped to set for the quality of the students at the Medical School have continued ever since his tenure and long will endure.

The three ingredients which determine the greatness of a medical school are its student body, its Faculty, and its curriculum. Of these three, the student body is the most important. The success or failure of the Committee on Admission will determine the fate of the school in the long run. The quality of the student body of the Harvard Medical School is such that year after year it attracts the most promising applicants from more than 200 colleges and universities. Since the best applicants wish to associate with the best medical students, Harvard has been more successful in matriculating the candidates selected by the Admission Committee than any other medical school.

**T**WENTY-NINE years ago, from 858 applicants Dr. Hale chose the 125 members who were to make up the immortal



class of 1941. We were subsequently reinforced by 20 more who transferred into the Third year. When I reflect upon my reaction to my classmates at that time, they seem to have been a sociable lot, but I was not aware of outstanding attributes that gave promise of greatness to come. Frankly, I think most of us were frightened to death, and not quite sure what we were doing here.

The fortuitous discovery of a bundle of old green cards, when we were moving the admission office, revealed to me both significant statistics and titillating interview comments about our class at the time they were being selected. (I'm going to burn these after this speech.) Almost a quarter of us had aptitude scores that were below the 80th percentile, and even two were below the 50th percentile mark. This is considerably lower than the 90th percentile MCAT score average of the class entering the HMS today. Also, a number of 1941'ers, who have now achieved positions of considerable significance in the world of medicine, ranked in the lower half of their classes in college. Worth Hale chose people for their personal qualifications rather than for their academic attributes alone.

I would like to illustrate this by quoting from three of their cards—a tipster's

report of long shots if I ever saw one. The first describes a man who is now a full professor. He was in the lower third of his college class with C's and D's in the sciences and an aptitude score of 67 out of 100. His characterization calls him a "sturdy, good appearing, intelligent fellow who has ideas of his own and seems well above the average sort."

The next is about a classmate who is now an assistant professor and who has a number of significant achievements to his credit. He too was in the lowest third of his college class and had 14 semester hours of D in chemistry. His summary states that he was "more impressive than his marks would indicate, clean-cut, well poised, seems to know what he wants."

The last is about a well known member of our class who is a leader in his field. He had an aptitude score of 71, C's and D's and even an E in chemistry. His card states that he was "outwardly bluff and awkward but both traits are blended with sensitiveness and good breeding in a peculiarly charming way, a most promising and desirable candidate." As you can see, in spite of what might be the most damning of academic qualifications, Dr. Hale chose to pick three people who have subsequently made their mark.

As we review the outcome of Dr. Hale's selections and consider the long shots that he backed, we find a rather impressive array of successes. In this class of 1941, now celebrating its 25th reunion, there are thirty full professors, fourteen associate professors, and fourteen assistant professors. I believe that this is the largest number of academicians produced by any class at the Harvard Medical School. One man has recently become Dean of Dartmouth Medical School; two others are assistant Deans. The academic stature of the class of '41 is well balanced by the success of the class in the practice of medicine and in research . . . that important triad that makes for success in medicine. Sixty-eight members of the class are practicing almost full-time and another twenty-eight are caring for patients on a part-time basis, while seventy-five do some teaching. Three members of the class have devoted themselves exclusively to research.

The members of the class of '41 do not confine their interests to the professing and the practice of medicine but include participation in a wide variety of civic, social, and recreational activities. An-

swers to a questionnaire for our twenty-fifth report shows that we have a great concern for the future of medicine. Many of us are hopeful that the benefits of the research laboratory can be made more directly applicable to the patient; we are concerned with the decline of the doctor-patient relationship; there is a firm belief that Harvard Medical School will continue to lead the way to the solution of these problems, and that Harvard will maintain a superior standard. As one of our reunioning class expressed it so well—"a perpetuation at the Harvard Medical School of a passion for excellence which warms us even in the hinterlands." If Dr. Worth Hale could be here today, I am sure he would be proud to see how well some of his long shot choices have come through in the race.

**N**ow some 25 years later the selection of medical students is much more highly organized. The Committee on Admission consists of 14 who were appointed because of their varied backgrounds in medical education and practice, perceptiveness, and their ability to evaluate people. The Committee spends countless hours interviewing, evaluating, and comparing each applicant with all of the others. They finally offer places to those applicants who, in the collective judgement of the Committee, present the most compelling reasons for acceptance, and they suffer agonies over the many outstanding young men and women for whom there is no room in the School.

It is a basic policy to consider all applicants regardless of race, color, creed,

sex, college, country of origin or financial status. Only the total assets of each individual are significant. Contrary to the convictions of a few Alumni, the sons and daughters of HMS graduates are afforded special treatment. If a legacy is in any way comparable to those other aspirants who are accepted, and it is believed that he can survive the rigors of the HMS curriculum, he is invited to join the class. To lower standards for Alumni offspring and take a person whose total qualifications are lower than those of a large number of applicants who could not be accepted would be both a disfavor to the student and a disservice to the school. As Dr. George Berry often said when faced with this challenge, "Caesar's wife must be above reproach."

There are major changes in the students who now apply to the medical schools. The quality of education during secondary school and college years is improving steadily. College level courses are now being offered in high school, and advanced placement credits make it possible to undertake work at a graduate level in college.

The result is an increasing diversity of education in the applicants who have already begun increasing specialization and increasing independent study. This fact poses a great challenge to the currently rigid lock-step, single-track type of medical school curriculum which has been in vogue since the Flexner report.

With increasing competition for places in college, medical school, and all graduate schools, there is at the present time, manifestation of a certain grimness of purpose and a lack of joy in learning



which is most unfortunate. Instead of viewing each stage of education as an end in itself, applicants merely consider it a necessary step to the next level. Last year we had 1087 applicants, most of whom were highly qualified. With so many superb choices to consider, the Admision Committee has had to determine which of these men and women will be the leaders of medicine in the year 2000. As we are all aware, there is blowing in the winds a great change in the practice of medicine. No one can predict what effects social and economic pressures are going to have on the way in which health care is distributed. Scientific revolution will continue and accelerate and we have to choose medical students who are going to be educable for an unknown future.

I am unaware of what intuitive or objective measures Dr. Hale used in picking the people who are our present leaders in medicine. The criteria used by the Admission Committee at the present time in selecting people follows these lines:

We look first for evidence of intellectual capacity, and, recognizing in the MCAT its limitations, we have to face the fact that each year there are several hundred applicants whose abilities, as measured by the test, are *above* the 80th percentile. We look for the ability to do scholarly work as shown by college records and by the products of independent study. Instead of simply taking a grade point average, we consider the major variation and the difficulty of the course recognizing that a B or C in an advanced course represents much greater growth and learning than does an A in an elementary course.

In the interview we look for maturity, evidence of originality and creativity, warmth of personality and emotional stability.

We are concerned about rigidity in the upbringing of applicants; students who have been taught that everything is black and white are unable to adapt to the grey areas which much of medicine and life presents. They find they cannot accept the fact that they do not know the answers to everything. We must find evidence of great integrity, because medicine is still a profession that will challenge the best of us when we have to make hard decisions.

We are greatly concerned with the emotional stability of our applicants, many of whom are qualified intellectually for the academic rigors

of medical school but cannot face the basic stresses of life, death and the most important of inner human relationships and emotions. This is particularly true of the students who are too young at the time they apply to medical school. We frequently counsel the bright young person who is ahead of himself in intellectual growth to take an extra year of fellowship or travel, or even an extra year of study in college, hoping that his physiological and emotional growth will catch up with his intellectual growth.

Much attention is paid by the Committee to the breadth and depth of an applicant's extracurricular activities and his summer work record. This is one way we have of evaluating his personality qualifications which are equally as important as his academic performance and MCAT scores.

This past year we became so concerned with the grimness of purpose of many applicants that we added another dimension to the qualities that we look for in students. We deliberately sought out those students who have shown a certain joyousness in their educational experience and who enthusiastically approached classwork, laboratory work, and extracurricular activities. It is hoped that this kind of student will take some of the pressure out of the self-imposed competitive atmosphere that we find at the Harvard Medical School. We hope they will bring with them a sense of adventure in the learning process which will make education a pleasant, stimulating and exciting privilege, and not just something that must be endured in order to get to internship and the real business of medicine.

**T**o FOCUS DOWN with a higher power on the problem of long shots and sure bets, I would like to discuss the Harvard Medical School National Scholars. The Harvard Medical School National Scholars were established in 1937, by gifts from Dr. Daniel F. Jones and Mr. Edward S. Harkness. The purpose was somewhat contradictory in these bequests: one was to encourage students of great promise and reward them without regard to financial need; the other was to make it possible for students of great promise to attend the Harvard Medical School who otherwise might not be able to come here unless the scholarships were available. Each year two or three National Scholars are selected by

the Admission Committee. A thorough study of the success in picking these Derby winners has not been completed, but a few facts may be of interest. Of the first twenty classes in which National Scholarships were awarded and in which the recipients graduated, that is in the years 1941 to 1962 (no scholarships were awarded between the years 1943-1945), there were fifty-nine National Scholars. During these twenty years, the Committee was successful seven times in identifying, before they ever matriculated, the men who graduated first in their classes. I would say that this probably represents a better choice of winners than any race track handicapper has been able to do. Moreover, twenty-six out of these fifty-nine were in the top ten of their class, and forty-seven of the fifty-nine were in the top third. To show that you cannot always win, there is one National Scholar who had the distinction of ranking in the bottom place in his class. At the present time, the Admission Committee still selects National Scholars as the most exciting and promising sure bets. Perhaps we should occasionally pick a long shot as a National Scholar to see what would happen.

It is perfectly possible to play it safe and pick only those students who demonstrate a high academic potential and a proof of academic success, but we are undoubtedly going to miss some future great men in medicine if we do this. Colleges are now showing wisdom by recognizing that a certain number of long shots must be selected for college classes, if unknown geniuses and leaders of the future are to be discovered. Likewise, I hope that in the future the Medical School Admission Committee may pick a certain number of long shots for each class. Then, I truly hope that I will be able to return to our 50th reunion and see whether our present admission committee used the same type of horse-sense that Dr. Worth Hale demonstrated twenty-nine years ago.



# Student Problems and Profiles



by

**Joseph W. Gardella, M.D.**

Associate Dean for Student Affairs

**TODAY** I shall impart no wisdom—indeed, imparting no wisdom is something I do with consummate skill. I shall attempt only to share with you my observations of the contemporary medical student and to present briefly some of his problems.

I shall begin with a profile of the students—not a categorization or an exhaustive view of their personalities, but an outline of their outstanding and at times perplexing characteristics.

Although their varied backgrounds—ethnic, social and economic—provide for wide differences in their values, it is apparent that almost uniformly, our students and their families place a very high premium on intellectual achievement. Not long ago, to most American families, success by any standard seemed sufficient. But today, both for the student and his parents, only academic success will do. They are convinced that society reserves for the academically successful its highest esteem and rewards. There is little question that the younger generation embraces this concept. Students at Harvard and elsewhere strive as never before toward academic excellence, and though they complain about the undue emphasis on grades and aptitude scores, they nonetheless find ultimate satisfaction in scholarly achievement.

In an era of unprecedented academic opportunity, one would expect them to

be content. Yet something is amiss. Students everywhere seem restive or in overt revolt. I have asked many students why this is so. What they tell me has much to do apparently with identity and idealism. Many students think we are in a social revolution. The young man at war with a society which attempts to press his identity into conformity and to direct his behavior along established pathways strives, he claims, to maintain his integrity as an individual. Society, he believes, strives to suppress it.

An important, possibly critical clue to the understanding of this conflict is perhaps revealed in the comments of students who claim that young people today are positively, not negatively, oriented to society and to the future. They are not, as accused, purposely destructive of current social standards. Instead, they are seeking their goals with positive purpose and with reason. Their conflict with society begins when the pursuit of their objectives is frustrated by traditional practices which they often regard as inhibiting, unenlightened, or inappropriate. They seek and expect change today and are not willing to accept a promise for tomorrow. This, I believe, is the singular difference that sets them apart from previous generations of young Americans. It is frustration from social inertia that causes them to become resentful and rebellious.

In recent years we have seen this

sequence of reaction at this school. For example, let us analyze the behavior of the two dozen so-called rebels of the present second-year class who, we are told, have repudiated the curriculum. You probably read about the incident in *TIME*—a publication that I find infallibly informed, except when it writes about what I know about. These young students had become impatient with an overstructured and overscheduled system of teaching that frustrated their efforts at learning. As one of them described the curriculum—the broadcast may have top rating, but the reception is jammed. They petitioned the Dean for immediate action and further proposed a program designed in the light of their own experience to enhance the effectiveness of study. Their goals were no different from those prescribed by the Faculty. Their action was not motivated by rebellious instinct but was based on their conviction that by their own devices they could do it better.

It should be clear to us by now that the contemporary student here and elsewhere has taken an active hand in shaping his destiny. He has done so because he is disillusioned with authority, distrustful of the wisdom of the present order, and frustrated by its inertia. He will yield only to reason and respect, but to the young our society gives little of either. Out of this ferment of unrest, irreverence and demand, there

seems to be emerging a society of new idealists who happily have as much concern for the welfare of others as for themselves; what they seek for themselves, they seek for all men—and they are determined to have it now. In recent years, the Medical School has witnessed a surge of student demands for opportunities to serve the social, civil, and medical needs of the community. Conferences, seminars, lecture series, and programs in the field of social medicine are sprouting throughout the School. If the Faculty lags the least bit in providing these programs, the students set about to create them. Many of their efforts, to be sure, are naive and abortive, but they are persistent, and they are pressing the Faculty to address seriously and actively the problems of social medicine in America and abroad.

**T**IME does not permit me to develop further this profile of the Harvard student. In essence he is intelligent, deeply committed to his purpose, much concerned with self-image, and filled with ambitions and generous ideals. I could talk for hours about his intellectual strengths and the scope of his accomplishments. And though these are well-known, I submit that he is even more gifted than his reputation would suggest. Today, however, I have elected to discuss his problems. But before doing so, let me make it clear that my remarks concern only a small percentage of the student body. To be sure, many if not most, have problems in adjusting to the School, but relatively few encounter serious difficulties.

What then is the nature and genesis of his problems? He enters medical school secure in his record of achievement and confident of his promise. The first ego-shattering blow comes with the realization that he is, for the first time in his life, no longer the obvious academic leader of his class. The very basis of his security, his academic superiority, has been challenged and he becomes filled with self-doubt. Virtually all students suffer this experience. The next jolt to his security comes from an unexpected lack of ability to adapt to new and unfamiliar intellectual tasks. At college, the material to be learned in any given course was circumscribed and limited. At medical school, when faced with a virtually infinite body of knowledge, he still seeks to learn it all and soon is overwhelmed. He has not before learned

to seek out principles and structural content; to determine the critical facts and with these data to reason rather than to recall the answers. For the first time in his life, his performance falters, and he now has evidence to support his fears of inadequacy.

As first mid-semester examinations approach, his anxiety reaches its peak. It is curious that at this time, attempts to reassure the student may provoke, rather than allay, his anxiety. He does not want to be told that his major defense against anxiety, namely superior performance on examinations, is no longer expected of him in every test situation. He is still much too grade dependent to find solace in this view. Thus, the least said about his academic performance at this time, the better, particularly since shortly after mid-year, anxiety in the vast majority of students abruptly disappears.

In those in whom it persists, anxiety begins to manifest itself in many different ways as the student seeks to protect himself. Some become guarded and withdrawn. They isolate themselves as much as possible from open contact with faculty and colleagues, and it may take a number of years before these unhappy young men can be drawn into easy and effective relationships with others. Some become rigid and hold inflexibly to old views and beliefs. Their resistance to learning, if persistent, obviously inhibits growth and performance. A few students compulsively persist in an effort to learn everything. They get lost in detail and only gradually and with great effort do they develop more effective methods of study. Still others, and there are many of these, deny the relevance or importance of the basic curriculum to preconceived careers, usually in the fields of psychiatry, public health, social or missionary-medicine. By discrediting the significance of the curriculum, this group makes poor performance less reprehensible and less self-damaging. A number accomplish much the same end through hypercritical and disdainful attitudes. A small, but very obvious group, strike out with hostility. Quite a few students lay the blame for poor performance on the lack of motivation for a career in medicine, but I suspect that failing motivation is more frequently the result, rather than the cause, of poor performance.

These then are the common expressions of the student's efforts to defend himself against anxiety and to

maintain his self-respect. In most instances, these problems are largely resolved during the student's career at school. If, however, his problems persist until his final year, or particularly if problems first become apparent during his fourth year, the student may not resolve his difficulties until long after graduation, and then only when he has become confident and secure in a particular and usually limited field of medicine. The extent to which the anxiety and stress of medical school serves to provoke or to uncover major psychiatric problems is difficult to assess. Thankfully, we have encountered relatively few such problems.

One of the most effective means to help these bright but sometimes troubled young men is to provide them with an opportunity to develop sound and penetrating knowledge in a special field of interest in close association with a member of the Faculty. While it may seem unrealistic to add to the workload of an already burdened student, he is usually successful in this endeavor. The skill that he acquires in dealing with scientific data and particularly the stability that he derives from the experience of proven competence does much to enhance the quality of his performance in his scheduled courses.

I have defined some of the basic machinery of the students' personality, and I have presented their emergent problems. What I have not done is to draw precisely the cause and effect relationships; here, of course, lies the real challenge.





# A Faculty View of the Curriculum

by Howard H. Hiatt '48

Herrman Ludwig Blumgart Professor of Medicine

**T**HE TITLE of my presentation permits me to interpret it in at least three different ways.

First, I might simply describe the plan of instruction followed during the past four years by the graduating class. This, on reflection, may be the only way that our curriculum may be discussed without evoking controversy. Second, I might attempt to describe certain of its serious defects. And, finally, I might suggest some guidelines for change. These last approaches are justifiable only if I stress that I have been asked to offer *a* and not the faculty view. (Since there are 617 people of faculty rank at the School, there very well may be 617 different faculty views available concerning what should be done to, or for the curriculum!)

The First year program followed by the Class of 1941 was devoted to anatomy, biochemistry, histology and physiology, taught in strictly departmental fashion, and it was similar to the program familiar to the Classes of 1916 and 1956. Let me remind the gentlemen of 1941 that you had two hours for lunch, that your formal exercises terminated at 4:30 P.M., and that in the second half of the year, on Tuesday and Wednesday afternoons, you were free. Life was somewhat less civilized 15 years later. One hour was allowed for lunch, and free afternoons were available only at the risk of displeasing the Department from which they were borrowed.

Nine years ago an approach to inte-

grated teaching was begun and it is this general outline that is now followed. During the first half of the year, anatomy, histology, biochemistry and physiology were taught as before along departmental lines, but during the second half of the year, integrated teaching of the respiratory, gastrointestinal and other nervous systems held sway.

Simultaneously, the Second year program was modified in such a way that while bacteriology, pathology, pharmacology and genetics are taught by the departments concerned during the first half year, the second half is devoted to an interdisciplinary approach to teaching pathophysiology. Until two years ago the Third and Fourth year schedules remained much as they had been previously, with the Third year devoted to one trimester of medicine and specialty, one of surgery and surgical specialties, one of pediatrics and other specialties, and the Fourth year was devoted to clerkship, medicine, surgery, obstetrics, pediatrics and psychiatry.

In the Fall of 1964, the clinical programs of both the Third and Fourth year were modified. The students spent 12 weeks, beginning shortly after Labor Day, in one of the four major general hospitals in a course called, Introduction to the Clinic.\* There the approach to the patient is stressed on the medical, surgical and pediatric floors, in a way that is

intended to prepare the student for his next duties as a clinical clerk. These duties are carried out in the succeeding year. The Principal Clinical Year begins in December of the Third year and continues through December of the Fourth year, with vacations during one of the three weeks separating the four, three-month clerkships. (One each in medicine, surgery, pediatrics obstetrics-gynecology, and one in psychiatry, neurology and orthopedic surgery and other specialties.) A reading period of two weeks precedes the last five months of the Fourth year, in which the student pursues an elective period in the clinics, in the basic science departments or institutions of the Harvard Medical School.

Despite the changes that I have described, the present curriculum is not radically different from that followed during our student days.

Let us next consider some of the shortcomings of this School's curriculum and then examine certain effects of the curriculum. This is a time when there have been extraordinary increases in the body of knowledge in several of the basic sciences. There have also been bold and effective changes in the way that this knowledge is disseminated in the secondary schools and colleges. There is, however, little evidence that the Medical School curriculum has been altered in response to the increasingly sophisticated and markedly varied educational experiences of the entering students. Career possibilities for the Medical

\*An article, "Introduction to the Clinic" appeared in the Christmas, 1965 issue of HMAB.

School graduates and the demands that society is now making on the medical profession have broadened enormously. It would be difficult to demonstrate how our curriculum permits us to extend the horizons for our students to include career opportunities in medicine or to meet the challenges of existing opportunities with the flexibility demanded by the changing patterns of medical practice. Do we even encourage students to pursue their self-generated interests in such spheres? Certainly, the content of our program does not suggest that the answer to this question is affirmative. Rather, we seem to operate on the thesis that all aspects of premedical science and of medicine must be offered in didactic fashion to all students. Thus we have a curriculum that is top-heavy with required material and which permits little opportunity for development of habits of individual scholarship. Some results of these defects might best be appreciated by examining certain experiences of the Class of 1968. This class includes 75 men and women who majored in science in college and 39 who did not. Immediately following their arrival, the students embarked upon a program that prescribed classroom and laboratory activity for 35 hours per week. You recall that the preceding year—the senior year in college—the prescribed classroom activities varied for the same group of students from 8–15 hours. And, that the classmates of these students who went on to Harvard Law School, for example, spent 16½ hours per week in classroom activities. The first year program for the students of Harvard Law School has two significant features: a free hour between 10 and 11 A.M. for coffee, and a lunch period that occupies all of the afternoon. The classmates that went on to do graduate work in physics at the Massachusetts Institute of Technology spent 16 hours a week in prescribed classroom activities during their first year, and those who entered the doctoral program in Medical Sciences here spent approximately 22 hours compared to the 35 hours we ask of our students in their First year here.

The course work now offered during the First year makes little allowance for previous experience, so that in histology, for example, an English major may find himself next to a student who did his thesis work with Professor Keith Porter of the biology department at Harvard College; and in the biochemistry course, a student who majored in biochemistry, perhaps under the tutelage of Professor

Konrad Bloch, may have been the neighbor of a philosophy major whose chemistry background was the minimum required for entering the Medical School.

While we can point to a considerable degree of curriculum integration, it is unlikely that it has kept pace with the merging areas of interest and expertise in the several departments. For example, during the past two years, the class of 1968 has had lectures on protein synthesis in at least four different departments. Although many details concerning protein synthesis differ as one goes from microbe to high organisms, the broad outlines of this process are similar, and one can reasonably ask, how much of this subject should be presented to the student who did his thesis work with Professor James Watson at Harvard College? Should four students, whose ultimate career goals are respectively, psychiatry, surgery, cancer research and population control, require equal exposure to this subject? And finally, under any circumstance, can a curriculum so heavily charged afford the luxury of so much repetition for any student?

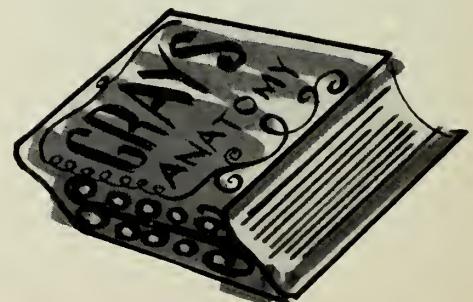
This extravagance is not limited to the basic science departments. In the endocrine area one finds that the morphogenesis, morphology and physiology of the thyroid gland are considered in the First year in a series of three lectures; the pathophysiology, pathology, pharmacology and surgery of the thyroid are discussed in seven lectures in the Second year; and at least one lecture on the thyroid is offered to each group of clinical clerks (at least at the Beth Israel Hospital), during the Principal Clinical Year. This is, of course, exclusive of the discussion concerning the thyroid that takes place at the patients' bedside.

**T**HE consequences of these shortcomings in the curriculum are becoming increasingly apparent. Our colleagues in the colleges suggest that some of their better students are losing interest in the prospects of a medical school education, including Harvard Medical School, due in large part, at least, to the rigidity of our programs. One needs to speak only briefly to our students to appreciate that they are not, in general, graduate students who are deriving great satisfaction from what should be an exciting educational experience.

Earlier this year, Dean Ebert charged a small committee of the Faculty, under the chairmanship of Dr. Alexander Leaf,

with the responsibility of evaluating the present curriculum and for suggesting possible changes, with the aim of providing the whole Faculty with a basis of discussion. Although our committee has not yet submitted its report to the Faculty, its members have already unanimously endorsed the urgent need for change, and for very significant change. While there is clearly no single formula guaranteed to be successful, the committee will suggest guidelines for the development of the new curriculum which I should like to paraphrase: First, the amount of factual information in memorizing imposed upon students must be sharply reduced. Students must be allowed adequate free time to read, discuss and think in a graduate school atmosphere. Second, a core curriculum should provide the common information in the biological, behavioral and clinical sciences expected of all doctors of medicine. It should not be aimed at didactic coverage of everything and should be taught in a limited time, preferably as a coordinated, interdepartmental activity. There must be time in all years for elective courses, designed to explore subjects in depth and taught primarily on a departmental basis. As much as 50 per cent of the curriculum should be devoted to the elective program, which would be planned by each student and his faculty advisors. The biological, behavioral and clinical sciences should be intermingled throughout the curriculum. And, finally, the motivation of the beginning student to help the sick, should be utilized by introducing him to the patient early in the curriculum. Such clinically oriented exercises should be designed to increase awareness of the emotional and socioeconomic aspects of illness as well as to illustrate the relevance of the pre-clinical sciences to the pathophysiology of disease. They should provide the student with increasing responsibility for the care of the patient as rapidly as his background and clinical skills permit.

In concluding I should like to express the view—again, a faculty view—that significant change is urgently needed.



# The World, the Flesh and the Harvard Man

by Carl E. Taylor '41

Professor & Director of Division of International Health, John Hopkins University

THE Church of England's Book of Common Prayer still has the plea dating from about the second century, "From the deceits of the World, the Flesh, and the Devil, Good Lord deliver us." I apologize to the Devil for the change I have made and hasten to say that I chose the phrase merely because it conveniently states the three headings which outline my comments. The World is the challenge to American medicine presented by international health; the Flesh is, of course, the population problem; and the Harvard man substituting for the Devil gives me a chance to make some comments on the ethics of international health.

I am particularly conscious of my responsibility to the unparalleled and unexcelled Class of 1941, that unequivocally climactic class about which you have already heard something today. I use the ecological term "climax" because this was the last class before the great educational watershed of the Second World War, and thus represented the peak of achievement of the whole educational process up to that time. Thrown immediately into the rigorous disciplines of war, our classmates developed a unique strength of character and awareness of the total needs of the world and a sensitivity to broad social and ecological implications of medicine which shows up clearly in their career development since that time. Now 25 years later the term climactic will probably have to be modified to climacteric.

The one word which most characterizes the world today is change. No longer do we in international health need to spend most of our energy overcoming the inertia of the social status quo to initiate change. Far greater contributions than ever before can be made merely by modifying the direction of change. We must work with rather than against accelerating demands among all peoples for health and social development. For me this is typified by the experience of my father and mother who are still in India after 53 years as medical missionaries. Their work in rural health was for many years a patient hammering against the mud walls of cultural resistance to change. Starting with independence

twenty years ago, the villagers' demands for better living have been voiced with increasing force. They complain against the government because they feel change is not rapid enough. I have asked the villagers why they are so eager for change now and gotten the response that now when they change it is for themselves.

The impact of foreign service at its best is illustrated by the story of the woodpecker who decided to be an international consultant. He flew all day across the deep forest; clouds were gathering, evening was approaching, and he was hungry, so he settled into the top of the tallest tree in the forest to look for his supper. As he made a tentative tap at a likely looking spot in the bark, a bolt of lightning struck the top of his tree! As the poor woodpecker lay, bedraggled and shaken on the ground, he looked up and saw that the tree was split from top to bottom. Suddenly it all seemed worthwhile. He exclaimed, "Boy! A guy doesn't know what he can do until he gets away from home!"

To be an expert in international work, all you need is the intuitive ability to time the taps of your efforts to the lightning bolts that are bringing spontaneous social change in most developing countries. In humbler moments, the international expert also accepts the definition which splits the word "expert" into its component parts: "X" for unknown quantity, and "spurt" for drip under pressure.

I HAVE coined a new word for the growing specialty of international medicine. I hope that classical scholars will not mind the slight distortion that has led me to "Ecumedicine." The word "ecu-menical" has more than theological overtones. It is derived from the Greek "oikoumenikos" which referred to what the Greeks considered the civilized world, and by implication to the unifying forces that bound the civilized world together. To be precise, our term should be "eeu-meni-medicine" because the prefix "ecu-" alone, I find from the

dictionary, is reserved for an old European term meaning "money," and international health certainly is *not* money medicine. You know the definition of "dedicated" is underpaid.

This would make a practitioner of ecumedicine an "ecumedicologist." You may have seen Sir Theodore Fox's recent article dealing with collective nouns. The distinguished ex-editor of *Lancet* started with the usual biological collective nouns such as "pride of lions and gaggle of geese." He then applied them to a well-known profession and came up with "a flourish of strumpets, a jam of tarts, and a pride of loins." He then moved to the medical specialties and gave us such choice terms as a "pile of proctologists, a stream of urologists" and we might add "a slough of surgeons and a gaggle of laryngologists." Much thought about an appropriate collective designation for ecumedicine has thus far produced only a rather insubstantial term conveying the thought that we are usually far away—an "echo of ecumedicologists."

The three points I have made about ecumedicine thus far are: first, like the woodpecker, you must be humble because you don't really contribute very



much; second, it is not money medicine; and third, that you usually are far away from home. In spite of these seemingly negative features, the specialty appears to be growing rapidly. A particularly sensitive indicator of a new wave of development is increased interest among students. By this criterion, ecumedicine has a great future. The present college generation is known for its concern about world trends and social implications; this is expressed in medical schools by the growing proportion of the best students who enquire how they can join what has seemed to be a rather exclusive club.

Next to people, the second determinant is money. President Johnson's personal interest holds the promise of major governmental support for university centers for international health and an international career corps in the public health service. In Congress, although the International Health Act has been delayed, it still seems necessary to justify this expenditure by showing that international activities protect Americans from exotic diseases, and that certain diseases can be studied overseas more readily than in the United States. As world citizens we must help those in need around the world because as President Kennedy simply put it, "it is right."

Some special emphases in ecumedicine can be illustrated by the range of activities now being undertaken by our Division of International Health. A basic discipline is geographical epidemiology. The antecedents for this specialty go back to Hippocrates' "Airs, Waters and Places." Much of the earliest and best scientific thinking about causation grew out of observations that diseases differed under varying geographical and social conditions. In the glamorous heritage of the pioneers of tropical medicine, there are still many natural experiments around the world waiting to be observed. Our geographical epidemiology unit is making comparative analyses of the health patterns of five primitive areas ranging from the Amazon headwaters and Andean highlands, to the deserts and rain forests of Chad in Central Africa, to Afghanistan, Borneo and Bhutan. A more specific example is the epidemiology of leprosy. This still mysterious disease was the first in which a bacterium was demonstrated to be the causative agent and yet it remains the last bacterial infection to be cultured and effectively studied in the laboratory. From observations on natural infections in

	PERU	TAIWAN	TURKEY
Crude Death Rate/1000	14	7	15
Infant Mortality Rate	95	28	165
Hospital Beds/1000	2.4	1.0	2.1
Discharges/100/year	3.3	1.0	3. - 4.
Physician visits (per cap.)	1.3	5.0	1.2
Persons per physician	2,200	2,200	3,100
Per capita G.N.P.	\$250	\$175	\$177

Table 1: Manpower studies in Taiwan, Turkey and Peru.

Bengal villages, we are trying to understand transmission and resistance. For example, the demonstration that acid-fast bacilli can be found in some clinically normal family contacts of leprosy cases raises the question of a carrier state.

A second ecumedical emphasis is the study of comparative systems of medical education. Many features of Western medical education are not appropriate in developing countries. Their appropriateness for the United States is also in doubt. On the other hand, a characteristic that we should export is our restless readiness to experiment with educational processes and patterns. Some medical schools in developing countries are increasingly focussing their teaching around the community concept. As U.S. schools become aware of their own community responsibilities we may profitably learn from our colleagues overseas. For 15 years we have studied the use of rural health centers as teaching laboratories. Medical schools in places as diverse as Turkey, the Punjab and Latin America are taking responsibility for the comprehensive health care of whole regions and including in their teaching facilities, satellite rural hospitals with networks of rural health centers. As our 5-year research project on the rural orientation of Indian doctors shows, the most attractive feature of present developments is the tendency of clinical specialists to participate in this increasingly exciting innovation.

A third area of particular importance in ecumedicine is the organization of health services to meet the current needs of society. The last World Health Assembly had as its main theme National Health Planning. Countries with the

most limited resources have greatest need for clear definition of priorities, and this requires research to develop new methods. We have just completed four national health manpower studies in Taiwan, Turkey, Peru and Nigeria. We found that Taiwan, Turkey and Peru (See Table 1) have essentially equivalent over all inputs contributing to health. Turkey and Peru have put much of their support into hospitals and have had little to show in improved mortality and morbidity rates, while in Taiwan the emphasis is on ambulatory and comprehensive care, and health achievements are dramatic. Everyone agrees that the more underdeveloped a country, the more they should rely on auxiliaries, but we find that the reverse tends to be true with excessive concentration on preparing professionals.

**I** TURN now to population, the fourth major area of specialization in ecumedicine and the central or fleshy theme of my title. Pervading all thinking about international health for several years has been increasing awareness of the implications of rapid population growth. A common tendency to oversimplify the inherent complexity of the problem is illustrated by the population expert who, in speaking to a woman's club, made the comment, "Somewhere in the world a woman is giving birth to a child every 5 seconds!" This was too much for a little old lady in the front row who jumped to her feet and demanded, "My goodness! Why doesn't someone find that woman and make her stop?!"

We have learned some basic facts. First, regardless of what we do now, built-in demographic trends dependent on the age composition of the population will

necessarily produce a tremendous population increase in the next generation which will be localized mainly in presently underdeveloped areas. Table 2 shows the distribution of the world's population in another 25 years. These minimum projections will be reduced only by major disasters such as famine or war.

Table 3 shows more dramatically than statistics one reason for India's famines. This map of the fields of one of our Punjab villages was made 100 years ago when the size of farms was shown by the heavier black lines. The minute grid of thin strips was produced by fragmentation of land among too many children.

The complex interactions of the family decisions are diagramed simply in Table 4. Family planning motivation pools behind the dam formed by the technical limitations of available contraceptive methods. Motivation must flow over this dam to get effective utilization. The motivational pool is filled by streams representing increasing numbers of children. The relative contribution of each birth to the motivational level gets bigger with each successive child, especially if they are males. Some contribution is also made by appropriate health education. The size of the pool is determined by traditional cultural norms represented best by the mother-in-law, and especially shown by the value attached to children. The motivational

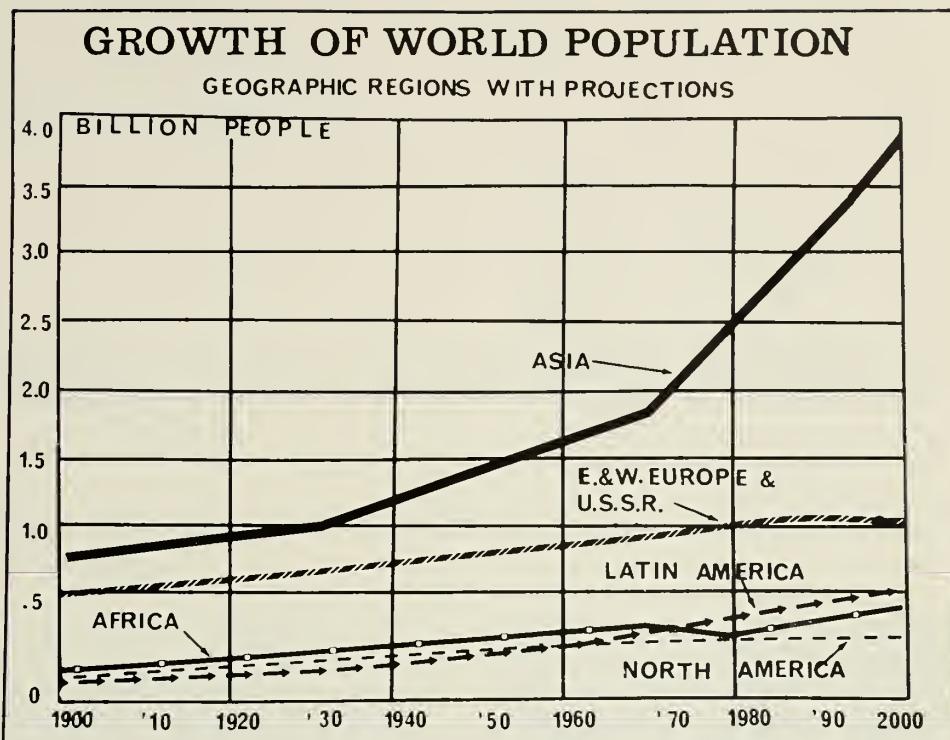


Table 2: Distribution of the world's population in another 25 years.

level in the pool has two major components. Family economics is mainly a concern of fathers and probably becomes maximally effective after conditions improve enough so that a few educated children are valued more than a larger number of hands for work in the fields. The negative effect of high parity on the health of mothers and children is of great concern especially to mothers, and seems strongest where conditions are

worst. Conversely, health also becomes an important positive force as families realize they no longer need to have 6-8 children to raise 3-4. Of great importance are the complexity, difficulty, repetitiveness, cost, and esthetics of contraceptive methods. It takes a high level of motivation to use conventional methods. New methods such as the intrauterine contraceptive devices may permit the flow of motivation into effective utilization after three children rather than the previous six, especially if the children survive.

In every community a sizable group of parents will immediately accept almost any new contraceptive that is offered. This immediate acceptance does not necessarily produce a fall in the birth rate since these parents tend merely to substitute the new method for previously used contraceptives or cultural taboos. They tend to have already had six children. In all countries so far, the initial sharp rise of I.U.D. acceptance levels off after the already convinced parents have been reached. We need to learn how to use the initial wave of acceptance as an educational process with satisfied users providing the best access to low parity families. The prospects are optimistic.

**W**E COME finally to the Harvard man and the ethics of international health. I find it necessary at this point to become a Devil's advocate in challenging

Table 3: Map of fields made 100 years ago in a Punjab village.



some basic ethical principles of American medicine. A new ethical orientation is needed to serve humanity in ecumedicine.

The massive and acute health needs in developing countries quickly overwhelm the carefully nurtured indoctrination of the medical ethic which requires maximum attention to each individual's needs. The task seems hopeless. The most sensitive physicians are the most frustrated as professional shock accentuates the cultural shock of anyone exposed to extreme need for the first time.

A doctor finds it difficult to think like an economist. Priority choices require hard decisions about balancing expensive refinements of individual care against the need to spread out limited health resources to reach more people. The individual-oriented clinical practitioner squeezes the last drop of excellence out of scientific knowledge, technical skill, and complicated equipment to gain a small percentage improvement in cure rates because individual patients are eager to pay for the best. When society pays for better health, alternative urgent needs demand fine judgment in balancing cost/benefit returns in social and economic terms. The implications of such cost/benefit analyses are repugnant to the traditional medical ethic. One cannot function in ecumedicine without developing this skill. Part of the attraction of specialty practice, whether here or overseas, is that it permits concentration on higher quality care for a few with less of this priority pressure.

An international health worker must learn to minimize his own feelings of alienation and to identify himself with local goals and hopes. He must intellectually and emotionally accept the people with whom he works to be accepted by them. Such cultural identification, however, should not be carried too far. He needs to live out the daily practices and basic values of his own culture which demonstrate a better way of life. When an Indian village development worker had tried to settle too completely into the village way of life, the local villagers told me that the only thing this proved to them was that improvement was hopeless. "If he can't do any better," they said, "what chance is there for us?" The specific formula which most ensures success in international health is to choose the right wife. Four years ago, when our family lived for a year in a Punjab village, my wife did

## FAMILY DECISION MAKING ABOUT USE OF CONTRACEPTION

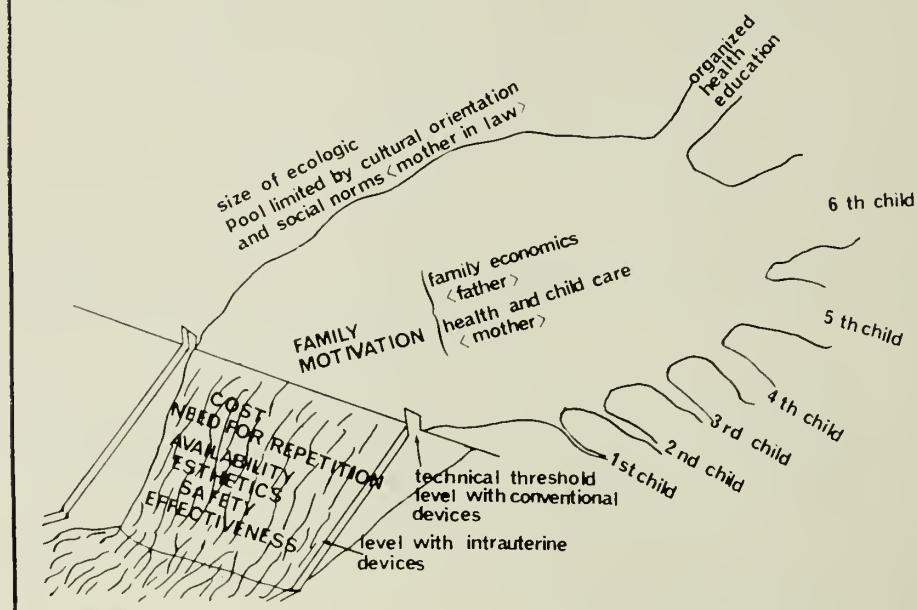


Table 4: Diagram of motivation for family planning.

a phenomenal job of making a sanitary and attractive home out of one of the worst houses in the village. We found that a considered and considerate selection of what can and should be changed can lead villagers to adopt new patterns of everyday living.

Medicine is one of the world's strongest instruments of peace. The need to share information and skills with colleagues in all countries requires continued free movement of medical people

and thought across national boundaries. Suffering is a world-wide responsibility. It is no accident that the first proposals for exchanges with mainland China are in health.

In closing, I speak directly to the medical students and young doctors here who are now making their career choices — Ecumedicine carries a fascination and a relevance to world needs that is a continuing new frontier for pioneering minds and spirits.



A

Round Table Discussion

on

# The Heart Disease, Cancer and Stroke Program

Moderator, Dean Robert H. Ebert, M.D.



Panelists, l. to r.: Henry C. Meadow, Associate Dean for Financial Affairs; Jerome Pollack, Professor of the Economics of Medical Care; Osler L. Peterson, M.D., Visiting Professor of Preventive Medicine; Claude E. Welch '32, Clinical Professor of Surgery; Lamar Soutter '35, Dean and Professor of Surgery, University of Massachusetts School of Medicine; Dean Ebert; and John H. Knowles, M.D., General Director of the Massachusetts General Hospital.

**DEAN EBERT:** The theme of this symposium is again one of continuing change and the problems of change as they touch all of us. The legislation of the Heart Disease, Cancer and Stroke Program is innovating in one sense and in another it is not. What is new is the type of problem we are being asked to solve; what is traditional is the manner in which the Program is being supported. We must now provide a framework for the delivery of care to be subsidized. But the really substantial challenge of this legislation is can we organize ourselves to really bring about a workable framework that will not interfere significantly with those values which all of us hold important? We would like to outline and analyze the framework of the legislation, report some of the things we have been thinking about here at the Medical School, discuss the impact on physicians and on hospitals, and, after a summary, throw the meeting open for general discussion.

# This is the Law

**PROFESSOR POLLACK:** In last year's wave of health legislation, one of the more consequential laws to be enacted were the amendments to the Public Health Service Act which established the Heart Disease, Cancer and Stroke Program. These amendments seek to stimulate co-operation between medical schools, physicians, hospitals and others in dealing with diseases which account for some 71 per cent of current deaths, to narrow the gap between medical knowledge and its application, and, "to improve generally the health manpower and facilities available to the Nation."

Of all the legislation this is perhaps the one that is least understood. The legislation is new in approach, its provisions are unusually vague and there is an unusual amount of confusion as to what was actually enacted.

In March 1964, President Johnson appointed a Commission on Heart Disease, Cancer and Stroke "to recommend steps to reduce the incidence of these diseases through new knowledge and more complete utilization of the medical knowledge we already have." The Commission, composed of distinguished professional and lay leaders and chaired by Dr. Michael DeBakey, concluded that there was room for material improvement in the prevention and management of these diseases. It stated that many lives could be saved by reducing the risk of coronary heart disease, and those stricken could be aided through new techniques of therapy. Many strokes, it said, could be prevented or lives saved through use of surgery. Biomedical research, it asserted, has already doubled and redoubled our store of knowledge, and with the emerging insight into the fundamental life processes, there is a promise of new weaponry—new methods of cancer detection and treatment and the successful replacement of defective organs.

The Commission advanced a sweeping program which called for the "immediate reduction and ultimate conquest" of these diseases and proposed a national network of regional centers and complexes for clinical investigation, teaching and patient care. New centers and new clinical research units would have to be built, it said, and new substantive authority required for construction, renovation, equipment and development of regionally oriented diagnostic and treat-

ment centers. Congress accepted the Commission's assessment of the problem and also the prospects for improvement and responded promptly with the crucial act of legislation. But it did *not* enact the *report* into law as many have supposed.

While intending to meet the report's basic objectives, Congress made major modifications, so major as to redirect the basic thrust of the Program. Rather than erecting new centers, it required that existing facilities be used, and prohibited the use of the Program's funds for new construction. It stipulated that no patient care would be provided except incidentally to research, training, and demonstration and unless the patient were referred by a practicing physician. It prohibited interference with professional practice or the administration of hospitals. It substituted the word co-operation for coordination to provide further assurance against interference with medical practice as now carried on. These and other changes headed off the thrust of the original program toward creating new centers, and redirected it toward the improved organization of existing resources on a regional basis. This regionalization would be voluntary and evolutionary.

Congress did not attempt to promulgate a blueprint for the nation. Rather, it invited the medical schools and the medical profession to plan, to invent, to experiment with a variety of programs responding to regional needs and local characteristics. And in hoping to inspire this innovation and improvisation, the law became unusually and intentionally vague. Its stated purposes, however, are not in the least vague. It hopes to encourage and assist in the establishment of regional cooperative arrangements for research and training, continuing education and demonstrations of patient care in these specified related diseases. It seeks to afford a better opportunity to the medical profession and to medical institutions, of making available to their patients the latest advances in the diagnosis and treatment of these diseases. By these means, however, without specific interference but through cooperation, it hopes to improve generally the nation's health, manpower and resources.

Appropriations totaling \$340 million are authorized over a three-year period: \$50 million this fiscal year, \$90 million in

1967, and \$200 million for 1968. The emphasis in the initial appropriation is on planning. The grants are to be made to public or non-profit universities, medical schools, research institutions and other public or non-profit agencies and institutions to assist them in planning regional medical programs and then to assist them in establishing and operating them. In seeking further to assure the cooperation of practicing doctors, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and other concerned organizations, institutions and agencies, the law requires that these be included in an advisory committee designated by the applicants for the planning grants, and that applications for operating grants would have to be recommended by such advisory bodies. A National Advisory Committee is established to advise and assist the Surgeon General in formulating policy and regulations and to make recommendations on the approval of applications and the amount of the awards. The Surgeon General is required, on or before June 30, 1967, to submit a report to the Secretary of the Department of Health, Education and Welfare for transmission to the President and then to the Congress appraising the activities of the Program, embodying recommendations as to its extension and modification.

This, in essence, is the law. The government has invited cooperation and the initiative of physicians and academic medicine to meet these broadly stated national goals. It has conspicuously avoided advancing any grand design. The President has told the Commission, "I expect you to do something about it," and the law in turn transmits the same expectation to the medical schools and the medical profession. The law is, in fact, an extension of previous grant programs, such as the Hill-Burton and Hill-Harris Act, and the support of medical research, but with an important difference—whereas they are addressed to the input side of care, the assurance of facilities, the training of manpower and the acquisition of knowledge—this Program represents a shift in attention to the outcome, to application, to delivery. It is the most advanced attempt to date to stimulate public and private cooperation in planning for improved care and probably poses the most significant challenge to both the public and private sectors thus far devised.

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**DEAN EBERT:** When we first began to talk about the implementation of the legislation for the Heart Disease, Cancer and Stroke Program in the New England area, Dr. Soutter accepted the responsibility of providing the leadership for a committee that was put together to plan the plan. Dr. Soutter will describe the progress made in the New England area.

## Planning the Plan

**DR. SOUTTER:** Last Fall, Dean Ebert and Mr. Meadow got together a group to start planning for New England. At first we were, of course, thinking largely about our own State of Massachusetts, but it soon became apparent that we had to broaden our view if we were going to handle the problem correctly. Over the months we have had a number of meetings with different groups and we have come to interpret what Professor Pollack has presented to you, into the concept of fact that this legislation is designed to provide an improvement in patient care, whether the patient is in a rural or urban area, and that the implementation of this Program is towards the fulfillment of that basic aim.

Governor Volpe and Lieutenant Governor Richardson became interested in helping us. They arranged a meeting with the representatives sent by the governors of the six N.E. states, at which we all attempted to plan on a rational basis. This planning has reached a successful conclusion, although the form in which the conclusion rests is somewhat different from our original concept.

Several other states had already proceeded planning on their own, particularly Connecticut and Vermont. Connecticut was quite far forward with its plans; and having a well coordinated hospital system, a very good public health system, two medical schools, and a population of some two million, it lent itself very well as a region for basic planning. In Vermont the legislature and the University had become interested in setting up planning and they had gone forward with it to a considerable degree. These two States were interested in co-operation but were not interested in forming a single region with a single planning group.

Maine, in its usual state of rugged individuality, had determined to go ahead on its own. In the course of the discussion, it developed that Maine had

the feeling that in Massachusetts we regarded their patients as the logical people to fill our hospitals. It was pointed out, in fact, that if you put a bandaid on a milestone and threw it into Penobscot Bay it would drift all the way to Boston! It was also pointed out that the last thing that Maine had from Massachusetts was \$30,000 in 1820 to help

Heart Disease, Cancer and Stroke Program offers the greatest opportunity the medical profession and the hospitals have ever had to improve, through co-operative effort, the over-all care of patients.

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**DEAN EBERT:** It has been Dr. Peterson's job, as an expert in determining the quality of medical care, to begin the planning for this Program in the New England area.

## Information First

them take care of the Indians, and even though we offered to go to the General Court and get them another \$30,000, they insisted they were going to go ahead and plan on their own.

New Hampshire and Rhode Island were much more keen on forming a region with Massachusetts. They felt the three States have a great deal in common.

It emerged that already we have a number of medical centers in the New England area: Burlington, Vt., Hanover, N.H., New Haven and Farmington, Conn., four medical schools in Boston, and Brown University, with its new school, in R.I. These would be the centers from which a variety of things would be distributed to the periphery, whether that periphery was in a town, city or rural area in northern Maine.

If we were going to have a plan that would work, we would have to coordinate this whole area so that we would all study the problems in the same way. After we had set up our plans we would have to be sure they did not overlap or interfere with one another and would be coordinated with what went on in New York State.

It was apparent that there were three definite steps to be taken. The first step—after a grant for planning had been secured—would be to find out what was the extent of the problem, second, what needed to be done, and finally, what were our resources.

As things are now set up, the tri-State region of Mass. N.H., and R.I., has a corporation which will apply for a planning grant. It will secure a number of individuals who will do the necessary study work for planning and then come up with a plan to be submitted to Washington. It will work through a regional corporation with the other three N.E. States so that we have good coordination of the entire plan.

I believe that the legislation of the

**DR. PETERSON:** When Lord Dawson of Penn, as President of the Royal College of Physicians, first proposed regionalization of hospitals in 1920, he had two things in mind; it would provide specialization between hospitals and it would be a vehicle for continuing education. In 1920 it was already apparent that knowledge was expanding so rapidly that it was going to become a problem for the practicing doctors. But, the most significant thing that has happened to the practice of medicine in this century has been the rapid growth of specialization. If we are going to plan, we have to consider what we are planning for. As I see the problem, it is most important to take full advantage of specialization. It, without doubt, has had an enormous effect on the quality of medical care and we should do everything we can to increase and exploit its effectiveness.

There are many things to examine before we can begin planning. I cannot go into all of them; instead I will describe a few of what I think are the major needs. Since there is a legislated reason for being preoccupied with deaths from heart disease, cancer and stroke, we propose to begin by studying recent deaths located through death certificates in order to determine whether any of them might conceivably have been prevented if the best possible medical care had been available. The problems of this approach are readily seen if one considers patients with myocardial infarcts. A large number of these patients do not live long enough to get to the hospital and some infarcts are very mild. We can do little to save lives when sudden death occurs.

In the case of cancer, it is necessary to look at the stage of the disease at first treatment. By this process, we hope to be

able to estimate whether there is really great potential for saving life. If we find this to be very little, we propose to shift our emphasis to the "related diseases," which are part of this Program.

If we are going to plan, what sort of things do we have to know about patients and about hospitals? I would like to illustrate the problem using some calculations. We know how hospital patients are distributed by diseases, from which we have calculated the number of patients admitted annually to Massachusetts hospitals. We have assumed that diseases such as myocardial infarcts were distributed among hospitals in proportion to total admissions. The hospitals with less than 50 beds would probably admit, in any given year, fewer than five patients with myocardial infarcts, fewer than five patients with carcinoma of the cervix, and about a dozen strokes. If a hospital is going to treat a dozen patients with diseases annually, it would quite clearly be hard to justify expensive treatment facilities for that disease. One begins to see that a stroke patient, to take one example, might be more economically treated elsewhere—in a more specialized hospital.

We have to know something too about the severity of the disease for intelligent planning. As Dean Ebert stated, we are today discussing ideas that are both old and new; it is clear that there is already some regionalization. For example, we already know that certain diseases, such as cerebral palsy and pediatric heart surgery, are treated in a few highly specialized units. But there is another kind of regionalization: When we examined the case fatality rates of various hospitals in Boston, we found that the patients with myocardial infarcts died mainly at the Boston City Hospital and the Massachusetts General Hospital. This is not because care in these hospitals is inferior but because these hospitals admitted the greatest number of high risk patients.

There is another aspect of this problem about which we have to collect systematic information. When we studied the experience of myocardial infarcts in one hospital—a community institution—we found that in a given year there were about 100 patients admitted with proven infarcts. Twenty-two patients were cared for by physicians who admitted a single myocardial infarct in the year. There were only 12 doctors in the hospital who were responsible for three or more patients with myocardial infarct in the

year. This is not good utilization of specialization. In surgery one sees very much the same phenomena. Apparently many doctors do some surgery but only a few do very much.

In addition to gathering data on the patients, the severity of their diseases and who treats them, we also have to find out how the hospital can react to a patient. What facilities and personnel can it bring to the patient's treatment? Does it have well trained consultants? What gadgetry does it have?

Many of you have heard about medical economics to the point where you are perhaps tired of it. The fact is that the proportion of our GNP spent on medical care has almost doubled in the last 35 years. We are obviously going to have to make choices in the future because this growth of expenditure cannot continue. The economists point out that we really ought to know both the cost and the value of our services if we are to make wise choices, but that we often do not know either one. Their argument goes somewhat as follows: "The costs of treating a patient in the hospital are not known because the cost of the hospital and much of its equipment is not known. The hospital itself is paid for by the community—Hill-Burton funds, contributions and the like—but it is never amortized, and it never appears on the patient's bill. Equipment such as the cobalt bomb is often donated by the Kiwanis Club or other organization; although its cost is not included in any balance sheet, it still costs society something to treat each patient. Whether the hospital uses this facility efficiently and often, or whether it uses it inefficiently and rarely is seldom known. Economists also point out that before you should say to some hospitals, "It's not economical for you to have a cobalt bomb," one has to look at the economics of getting medical care far afield. What sort of constraints and costs will be imposed on the patient if he has to travel farther to get necessary medical care? This too has its cost.

There are a few other things that we must know more about. In this country we have neglected the post-hospital period. All the studies of what happens to a patient after hospital discharge indicate that often hospitalization has done little good. This may be due to the character of the patient's disease, or to a lack of facilities to help him maintain the well being achieved in hospital.

We cannot neglect the problem of

personnel. In examining the age of personnel in one state, I found the median age of doctors in one-doctor towns was about 55 years old, whereas the median age of all doctors was about 45. Clearly the doctors in one-doctor towns are dying out. We must begin to think about alternative methods of providing care to the areas that are now losing their last doctors.

Last and not least, but perhaps most difficult, we have to know more about our population. What we see in a hospital is a highly selective part of the population's disease load. We cannot deduce from it how well the hospital is meeting society's problems. We have to find out more about disease in the population and the extent to which the hospital is meeting it.

Before we *can* plan, we have to have a great deal of information, and for the next few years we are going to try to supply this information.

## The Local Level

DEAN EBERT: Dr. Welch, who is the immediate past president of the Massachusetts Medical Society, will discuss the impact of this legislation upon the physician.

DR. WELCH: We of the medical profession must recognize that we have to do some of the planning or someone else is going to do it for us. One of the impacts of this legislation is that the planning is not going to be superimposed from above, but is going to have to be done at the local level. Unless it is done at this level, it will not be accepted by the Advisory Committee.

In general, the medical profession was opposed to the original Bill. But as we have seen, the Bill has been changed considerably. There are three important things that it is designed to do. It is designed to promote regionalization, to promote patient care, and to improve the education of the doctor. All of these will affect the medical profession intimately.

The doctor, wherever he may be, in a medical center or out in practice, must recognize that his education is out of date and that he must be educated continuously. I do not think many of you realize how difficult postgraduate education really is. The Massachusetts Medical Society has been engaged in postgraduate education for many years and we are

faced with a tremendous amount of apathy in the medical profession. No one wants to go back to school. Yet everyone admits this is something that needs to be done. But how is it going to be done? I do not think that it can be done by a series of specialized lectures with one man going out to a hospital and giving a lecture. There will have to be some give and take between the profession—between those in the city and those outside. We will have to set up some method whereby there can be a flow, a circulation, from the center to the outside and then back again to the center. I think that by this method of active participation we can educate both the doctors in the outer areas and those in the centers.

As regionalization progresses, there is going to be an increased trend toward specialization and group practice. This is implicit in the legislation itself which started out as a categorical treatment of disease. Such specialization will probably lead to a diminished number of local practitioners. We are going to have to carefully design a plan for the referral of patients from the local areas into the center. This will be difficult to work out because of local jealousies. Every hospital believes that it can have every type specialist under its roof. In the coming society, however, this will no longer be possible.

It is conceivable that it might be possible to layer out a group of local practitioners isolated from the groups working in the center area where the research and more highly classified teaching is being carried on. I hope this will not happen. If such a stratification of the medical profession should occur, I believe we will lose one of the greatest values of the proposed Bill. Only if we recognize the value of the postgraduate medical institute, that has been developed over many years and supported by the Massachusetts Medical Society, will we be able to accomplish what is envisioned in the Bill.

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# In the Hospitals

**DEAN EBERT:** Dr. Knowles will speak to you on the impact of this legislation on the hospitals.

**DR. KNOWLES:** We medicine men are basically anti-bureaucratic. The word plan itself usually raises large allergic welts on the average doctor because it smacks of the socialist state and the Communist's five-and ten-year plans.

I have no magical words about the positions of hospitals in this planning. It has been my contention, and that of Dr. Ebert's, that with or without federal financing, the hospitals and the medical profession should have begun this planning years ago on their own.

When we had our first meeting on regional planning with the Dean, Dr. Souter and a group of the medical faculty, I suggested to the Dean that I could go to the North Shore and talk, once again, to the 16 hospitals there who were trying to group themselves together for the purposes of regional planning. I was there first about a year-and-a-half ago. I took copies of the new Bill, I explained the whole history of regional planning beginning with the Hill-Burton Act, and I told them about Medicare itself, which by its funding mechanism, may or may not give depreciation money to hospitals. Don't tell anybody but there is a much stronger central control involved in regional planning through the Medicare Act than the Heart Disease, Cancer and Stroke Program ever thought of having. If you do not fund the depreciation, central authority may decide that you should no longer keep those particular buildings if they are not utilized properly. This is a much stronger lever for centralized regional planning than the Heart Disease, Cancer and Stroke Program.

I suggested to these 16 hospitals that instead of waiting for "big brother" to send money with all kinds of strings, they get together with the Massachusetts General Hospital and the Harvard Medical School. We could decide how we might rationalize what we are doing, avoid duplications, spot our deficiencies, and try to improve the whole system. We could begin with noncontroversial areas like the sharing of house staff, lecturers, or teaching programs. Then I retired gracefully back to my office at the MGH and waited. Six months later I made another trip and gave the same speech, and three months after that, I made the same speech again. To this date, the 16 hospitals have not been able to agree on their own formal getting together. There is deep suspicion that "big brother" in town, namely the MGH, is going to rook everything, in terms of some mysterious hidden agenda. This is one experiment in regional planning and if I had to make a bet right now, I would have to bet that the medical profession and the hospitals in this State are simply not going to do this planning gracefully. They are not going to maintain their freedom because they are unwilling to exert the necessary responsibility without fear of sanctions.

When we talk about regional planning in hospitals, we have to get through the current conventional wisdom about obstetrical facilities. At this point, we have to come to grips with the Catholic Church which is a powerful group when it comes to regional planning in hospitals. Then we go to pediatric facilities which are under-utilized across this State today and then to the popular stories about cobalt bombs and open heart surgery. After this, no one seems to say much more because the fact of the matter is that in this State and in this country, the technical facilities and available beds in hospitals and nursing homes are grossly inadequate to the task right now. Never mind what is going to happen on the first of July!

The first principle of any regional planning must be to improve the service. Any saving of money is always a secondary gain. There has not been successful regional planning in this country to date that has not resulted in an increased capital expenditure for medical care



facilities, I would defy anybody to show me where it has saved large sums of money because regional planning inevitably uncovers existing deficiencies and demands that the community or local government support expanded facilities.

There is a hidden plus in regional planning. During our first meeting, someone said that we could easily regionalize the care of patients with acute myocardial infarct. Everyone is in agreement on how to treat it—we all know the technical facilities needed. "Is that so?" I said. "One month, when I was visiting Bulfinch V they were using anti-coagulants and elastic stockings all day. The next month, I went to Bulfinch I and the house staff would have none of that." Here is the hidden plus. This planning is going to make us rationalize some of the things we have never been able to explain to each other before. First of all we will have to decide what indeed is the best treatment for all of these diseases.

The only other statement I have about regional planning is that the first and foremost problem is selecting a politically viable unit of planning. To my mind, and I am sure Dr. Ebert and the rest of the speakers you have heard feel this way, a very viable unit of planning is the Harvard Medical School with its seven affiliated teaching hospitals. I can assure you that there is absolutely no communication among these seven hospitals and the mechanism for it does not exist. We are all fighting hammer and tongs to keep our territory protected. We are even thinking of building a moat around the MGH. So let's let charity begin at home. Let's substitute action for words. The Medical School and the University is the thread that is forever woven through the seven hospitals. It is the force that could bring about this regional planning. It can be done on a strong University base and the time to start it was yesterday.

In this day of expanding bureaucracy and fat administrators, we must not forget that the elemental concern of medicine is for the patient and for his physician. Without these two people, we do not have medicine. Their needs must be considered by the planning boards. The intensely personal nature of their relationship cannot be ignored nor should it be subjected to the starvation of expanding bureaucratic controls. Here again, detailed knowledge of the sociology of doctors and patients is needed if our facilities are to be used rationally.

With the University playing a central

role in planning, the problems of manpower must be considered. We are dreadfully short of manpower today at every level, whether it is doctors, nurses or technicians. There is not a hospital in this State that is adequately staffed in any area. While we build our facilities and rationalize the ebb and flow of patients and doctors, there must be companion efforts made to get the people and facilities with which to carry out these plans.

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## Summary

**MR. MEADOW:** You have just heard from experts, but I am not an expert, so I would like to take an overview, which will be my own, and share it with you. I hope this will enable you to see, as I do, some of the interrelations of the things developed by the speakers.

Dr. Ebert made two fundamental points. He emphasized that the plans and programs contemplated by the Heart Disease, Cancer and Stroke legislation touch on all of us, and he stressed that this legislation is going to be a challenge to you not only as physicians but as people who have a responsibility for the health of the other people in this country.

I would like to emphasize the enormous complexity of the problem. This legislation is going to tax our ability to organize and deal with the many individuals and organizations who are involved and who are going to continue to be involved in improving our ability to deliver medical care.

Professor Pollack pointed to the origin, evolution and finally, the form which this legislation has taken. He emphasized its broad base in the community and the need for public and private cooperation.

Dr. Soutter discussed the evolution of our own planning and thinking in Massachusetts and in the New England area. In spite of the different problems of the different states, enough goodwill and understanding has been generated by those involved so that we have been able to come together and agree that the problem requires common understanding and a common approach.

Dr. Peterson stressed the importance of knowing what the problems are. He told us that expenditures as a percentage

of the Gross National Product in this country for medical care have increased twice in the last 35 years. This fact is evidence that medicine can do more for people rather than that medicine is more expensive now. It is important to look at this aspect of the situation.

Dr. Welch gave you his personal reactions as a physician and also as a man who has been a leader in the physician's community. The point he emphasized is that all of us must face up to these problems as part of the private sector or else someone else is going to do it for us. We have to rationalize; we have to regionalize; and above all, we have to educate our physicians.

So far as Dr. Knowles' presentation is concerned, I think he would be the first to accept an addendum I should like to make to his postulate, that Harvard had better plan for itself. Harvard, in doing things, has very often pointed the way for others and I think if we are going to do this for ourselves, which I am sure we are in part, we have a responsibility for doing it in such a way that others can emulate us.

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The following questions were directed to the panel:

**QUESTION:** The level of abstraction of this discussion was such that I was unable to get a clear picture of exactly what anyone has in mind.

**DEAN EBERT:** I think that probably reflects the way the legislation is written.

**DR. SOUTTER:** I do not believe that there is going to be a uniform pattern in the centers. I think they are going to vary from one part of the country to another and I think in this part of the country, they are going to vary very much. I think if you take a look at the University of Vermont as a center, you see a small medical school with a large part of its clinical faculty supported by practice, not a large number of people who are full-time and therefore, able to turn their energies to new things. Whereas, if you take a look at Harvard, with all its hospitals and so forth, you see a vast number of people who can serve in one way or another in this Program. I believe that as time goes on, the centers will become more and more uniform because they will have to plan along much the same lines as to how they are going to deliver education, services, and training to the periphery where it is needed.

**PROF. POLLACK:** When I originally looked at the legislation, it reminded me of "The Hunting of the Snark." It was vague; it was "meager and hollow, but crisp." It was unclear as to how the legislation intended to accomplish its goals. On closer inspection, its directives are very clear. The DeBakey Commission said that one half of the deaths from cancer could be prevented. I do not know whether this is true, but that is what Congress was told, and that is what it reacted to in passing the law. The people expect something to be done; this is what the President said. The question is, what will medical education and the medical profession do about it? When the Surgeon General makes his report there will be a need to show specifically what has been, and what can be accomplished. This is a real enough mandate.

**QUESTION:** Do you think that implementation of the Program would actually cut down the number of deaths from heart disease significantly? And do you not think that perhaps the emphasis should be on preventive medicine?

**DR. PETERSON:** There was emphasis not only of the number of deaths that could be saved but also on the years of life and the consequent economic gains that the country would make from this. There would be situations in which medical care would make the difference. People are dying from these diseases at an age when they are at a very high risk of dying from every disease. Dr. Alex Burgess assumes from his recent calculations that we could realistically reduce the U.S. infant mortality rate to that of Holland's. The argument goes, if Holland can do it, we can do it. We could do this through preventive medicine by eliminating about 20,000 of the infant mortality deaths that we now have. But, to produce the same increment in man years of life, we would have to save about 50,000, or two-and-a-half times as many cancer deaths. I do not think we are going to get much gain in life from the Heart Disease, Cancer and Stroke Program.

**QUESTION:** Is the shortage of nursing personnel the worst blockage to everything we are trying to do to give good patient care?

**DR. KNOWLES:** Yes. Today we have about 500,000 nurses in this country. There is not a hospital in this city right now that has enough nurses and there are several hospitals that have had to close floors in the last several months because of a lack of nurses. Of the 750

nursing homes in this state, there are not more than 300 of them that have even one licensed nurse on the premises. It was estimated in a study by the National League of Nursing that by 1970, we should have a minimum of 800,000 nurses in this country. They made that statement and at the same time, they raised the flag for doing the diploma schools out of business, phasing them out, and putting all of nursing education in the university, recognizing that today 75 percent of the nurses in this country are produced by the hospital schools. When they estimated going from 500,000 to 800,000, they hoped that the 75 percent of the supply that came from us would be about doubled. The university would add about 10 percent somehow, somewhere. The nursing world right now is at odds with itself on this. The nursing homes of this state are not going to be accredited for Medicare reimbursement because they simply do not have the nursing part of the nursing home. What the Heart Disease, Cancer and Stroke law, along with the Medicare law is doing to the public today, is raising and skyrocketing their expectations that somehow with government subsidies, the problems will be solved and by central authority, all will be well. It just is not so. We do not have the technical facilities or the manpower to carry out the spirit of these laws. The next thing I think we are going to see is a more sound review of the manpower situation. Dr. Ebert was recently appointed to a Presidential Commission to come to grips with this problem of manpower.

**QUESTION:** What can research contribute to this Program? This seems to be a logical followup on the question of what preventive medicine can do. Obviously, even with the best medical and nursing care, we will meet a plateau unless we have new knowledge in these fields. I am affiliated with a university where we have about 15 people pecking away at different parts of the arteriosclerosis problem. As far as I know, nowhere in the U.S. is there an institute devoted to research on arteriosclerosis on an interdisciplinary basis. It seems to me that our school could well consider establishing such a program which I am sure would bring research workers together on one of the most difficult areas we are facing today.

**DEAN EBERT:** As I understand the legislation at the present, while research would be encouraged, it will not be specifically financed from this Bill. I

think the question you posed is one, perhaps, which would be more in the sphere of the NIH in their other role, because they will also have a role in administering this Bill. One would hope that the roles would be coordinated, but no guarantee is necessarily forthcoming.

**QUESTION:** In the past Harvard has always emphasized research and it has not given, I think, adequate recognition to the teachers. What is being done by Harvard today to foster good teachers?

**DEAN EBERT:** In the last twenty years the manner of support for full-time faculties was clearly identified for research. In a sense teaching became somewhat peripheral. This has been reflected in this University and other universities in the manner of promotion, advancement and position. I think several things are going to have to happen: first, the faculty itself must acknowledge the importance of teaching, and secondly, there has to be further recognition of the importance of teaching in terms of support from the private sector and perhaps also from the public sector. There is a growing awareness that to support only the investigative aspects is really not enough, because in a sense, it defeats the purpose of a medical school or university.

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**DEAN EBERT:** I hope that it has become clear that the challenge of this legislation is a real one, that the questions raised by it are those all of us must participate in answering. I think it is apparent that we have to break down some of the moats we have built around our institutions to determine whether or not, within the particular community in which we live, we are performing the most useful and valuable function. I feel as strongly as I can state that the best system of medicine is the private system, and it is the only system which is workable in this country. But in order to make it work better, all of us, as physicians, are going to have to look at ourselves and our roles in the community, the use made of our hospitals, our groups and our individual offices as social instruments. This area in medical education has been neglected. I think it is reflected in the fact that we are not terribly able to respond to this kind of challenge. I think we have the wit to do so. I think that we have the energy to do so. And I think we are going to have to learn how to do so.



1916



1921

1926



# Reunions

## '16 PAUL R. WITHINGTON

Fifteen members of the Class of 1916 and 12 wives gathered to celebrate our 50th Reunion. Those present were:

Dr. and Mrs. Theodore H. Aschmann  
Dr. Maurice T. Briggs  
Dr. and Mrs. Caludius V. Calvin  
Dr. Kenneth Churchill  
Dr. and Mrs. Ross Golden  
Dr. and Mrs. Hilmar Koefod  
Dr. and Mrs. Alfred G. Langmann  
Dr. Franklin P. Lowry  
Dr. and Mrs. John H. McIntyre  
Dr. and Mrs. Samuel L. Morris, Jr.  
Dr. Andrew Nichols 3d  
Dr. and Mrs. James J. Putnam, Jr.  
Dr. Henry R. Viets  
Dr. and Mrs. Paul R. Withington  
Dr. and Mrs. Stanley B. Weld  
Mrs. Goethals  
Mrs. Lanman

On Friday evening we had our Class Dinner in the auditorium of the Countway Library after which Mrs. Moore very kindly took us on a tour of this magnificent building.

On Saturday, wet, and lost at times, we all made it to the Withingtons in Milton for luncheon; and there was much talk of our infinite relief that we were too old to be entangled in the administration of Medicare.

We are very grateful to Dorothy Murphy, who, as usual, gave us special care. Her infinite patience kept us all out of trouble. The Class was particularly delighted to have Mary Goethals and Gert Lanman join us for our festivities.

The highlight of our 50th Reunion was the abundantly flowing champagne toast from the 25th Reunion Class. The old order is grateful to the new.

## '21 JEAN A. CURRAN

Thirty members of the Class of 1921 and 23 wives made a brave showing at our 45th anniversary to enjoy the best get-together yet.

The Alumni Day program, held under marquee, in the dazzling surroundings of the Countway Plaza, brought us up to date with what is going on at the School. In the afternoon, interrupted now and then by the thunder of jet planes, we were enlightened by a galaxy of talent on what to expect of the Heart Disease, Cancer and Stroke Program.

As usual we sat for a class picture to mark our quinquennial reappearance, after which we enjoyed a most convivial luncheon in the Longwood Quadrangle.

During the perfect weather of the afternoon, class wives enjoyed visits to the Matisse Exhibit at the Museum of Fine Arts and the Isabella Gardner Museum. Mrs. Eva Vela-Gonzalez, who had come all the way from Mexico, was given a special tour of Boston, Cambridge and Harvard Yard.

As has been our custom in recent years, it was our good fortune again to be entertained by the Kazanjian family at their beautiful home in Belmont. After suitable libations and good fellowship, Bill Castle, our master of ceremonies, presented to Dorothy Murphy, our loyal friend since student days, an engraved Revere Bowl as a symbol of our appreciation and affection.

A sumptuous dinner was served under a splendid marquee in the garden, and we were honored by the presence of our guest, Claude Emerson Welch '32, clinical professor of surgery and president of the Massachusetts Medical Society.

We stood for a moment of silence in memory of the nine class members who have departed this life since our last reunion. The death of Samuel Rideout Webber leaves us without a permanent Class President.

Marion & "Kay" Kazanjian, our gracious hostess and host, were surprised with the gift of a Steuben glass bowl which we presented as a token of our appreciation. Toasts were drunk to all who had contributed to making our gathering so enjoyable.

Alumni Days have invariably enjoyed "luck of the Irish" weather over the years but for the second year in a row, the heavens opened on Class Day. We

were most impressed with the fine looking graduating class of 141 and their achievements (including attractive wives and children!).

Our own Class finale was the luncheon at The Country Club. Gus Thorndike, president of our class our first year at HMS, proposed toasts to Langdon Parsons and Dorothy Murphy who had done so much to make arrangements for us. Dorothy responded appropriately. A special word was sent to William Hughes who, unfortunately, at the last minute, was unable to join us.

Our 45th Reunion caused Isabell Chipman to burst into "verse." She and Horatio Sweetser sang the composition as a duet to the tune of the wholly appropriate "Auld Lang Syne."

Here's to the Class of twenty-one  
It's great to be together.  
We eat and drink and have some  
fun  
No matter what the weather! . . .  
. . . Let's all keep well for five  
more years  
Great Class of twenty-one  
And meet again with you dear  
friends  
In Nineteen Seventy-One.

## '26 WALTER S. BURRAGE

Forty members of the Class of 1926, together with 31 wives, registered for the 40th Reunion after congregating from 11 states. First prize for mileage in transit went to the Hugh Leavells who came from New Delhi, India. Jed Gray, Jeff Larkey and the Bill Boeeks made it from California. Harrison Huggins from Montana. Don Kingsley from Nebraska. Billy Potts from Texas, the Warren Cookseys, the Jim Wilsons and the Cameron Haights from Michigan, the Isadore Levins from Ohio, and the Ernest Scotts from Virginia.

Friday evening the Class assembled for cocktails and dinner at the Ritz Carlton under the supervision of Gourmet Gunderson with Dick Stetson mastering the ceremonies. Orator Clarke Heath ex-



plored the important topic of the Rededing Hair Line with its relationship to the fecundity and sexuality of the offspring. President Mallory gave to guests, Dr. and Mrs. Robert H. Ebert, a most cordial welcome. In reply, the Dean mentioned the important part played by numerous members of the class in the activities of the Medical School.

On Saturday afternoon, the outing and clambake at Manchester-by-the-Sea resounded to the music of steady rain on the tent top and the wail of fog horns. Visibility was zero; even the Atlantic Ocean had disappeared. Myopic vision, however, proved more appetizing, thanks to the foresight of Alumni Directors Lang Parsons and Dorothy Murphy and such stimulants as adequate fluid intake, steamed clams and lobsters.

On behalf of the Reunion Committee, I want to congratulate Claude Forkner who, with Mrs. Forkner joined us for the reunion. His outstanding performance as National Chairman of the recently concluded Program for Harvard Medicine merits the thanks not only of members of the Class of '26 but of all Harvard Medical School Alumni.

### '31 CHARLES F. WALCOTT

The Class of 1931 had a most successful Reunion with a total of 45 members of the Class and 37 wives attending.

Our Class Dinner was held in Kresge Hall on Friday evening. A total of 81 were present, including John Stewart, president of the Alumni Association, and his wife as our guests. The success of the evening was assured by President John P. Hubbard who presided with consummate skill and gave an entertaining and

instructively illustrated discourse on National Board matters. Iggy Thompson showed slides and gave a fascinating talk on his three tours of duty in Taiwan as an orthopedic consultant. My poem was kindly received by those present, after appropriate liquid preparation.

Since Science states, it must be true,  
Our birth-place was the ocean blue,  
And each man's bodily self contains  
Oceanic fluid in his veins,  
Maintained, despite our "ids" and  
"isms"  
By homeostatic mechanisms,  
So that all our electrolytes  
Are kept in balance days and nights,  
Shakespeare's old adage follows  
then,  
"A tide's in the affairs of men!"  
And that is why we must abide  
The ebb and flow of ocean's tide  
And seasonal appointments keep  
Like funny denizens of the deep.  
The salmon leaves his natal stream

To seek the ocean's distant gleam,  
So each of us has fared afar  
Each following his own lode-star.  
It's thirty-five long years ago  
That each set out his row to hoe!  
Somehow to ocean's stilly deeps  
We know Spring's vernal message  
seeps  
Telling each Salmon, Herring, Shad,  
"Come, rise and shine, wake up,  
my lad!"  
How this is done we cannot see  
Perhaps some mer-maid, Dorothy  
Murphy,  
There weaves her spell and breaks  
their dream  
And guides them to their natal  
stream!  
Is it not right that we should be  
As wise as fishes in the sea  
And heed Spring's vernal message  
clear  
On this, our five and thirtieth year?  
Then leave your task while yet you  
can  
And meet together as a clan.  
To celebrate in ancient form  
This festival, while we're still  
warm!

On Saturday afternoon 55 of us enjoyed an outing and clambake at Hap Kennard's lovely place in Newton. Despite the showers, the lawns, flowering shrubs, flowers and trees all looked their best. Hollis Albright's golf competition, with a bottle of champagne on a pole as target, was a great success. The less skilled showed their youthful spirit by playing frisbee. The total of 55 present included Lang Parsons as our honored guest.

The Class is deeply grateful to Hap Kennard not only for the use of his lovely estate, but also for the thought and effort he put into making this such a successful and enjoyable outing. In addition,



tion to the other members of the Committee, special thanks are due to Dorothy Murphy and the members of her staff who made this reunion possible.

### '36 HOWARD ULFELDER

Forty-two members of the Class of 1936 registered for our 30th Reunion. Most came from the New England and New York area but Virginia, Ohio, Illinois, Pennsylvania, Texas, Oregon and even Puerto Rico were represented.

The delightful weather on Alumni Day encouraged our lingering over the luncheon al fresco and we quickly reestablished old ties. Friday evening we went to the Longwood Cricket Club for dinner and dancing.

Saturday the heavens opened but at 3 o'clock the rain ceased, almost exactly according to the pattern of five years ago. By bus and by car we converged on Duxbury and enjoyed the spectacle of a real New England clambake presented by an acknowledged master of the art, Elmer Glass. Many wives and children came and after much informal chatter, 84 of us sat down, elbow to elbow, to enjoy the sweetest clams and the most succulent lobsters ever tasted.

### '41 JOHN W. RAKER

The Class of 1941 gathered for its 25th Reunion at the Harvard Club on Thursday evening. We were honored to have as our guests, Dr. Churchill, Dr. and Mrs. Enders, Dr. Finland, Dr. and Mrs. Krayer, Dr. and Mrs. Parsons, Dr. and Mrs. Stewart, Dr. Burwell, and Dr. and Mrs. Ebert. Unfortunately, other honored guests could not be present,



and we missed Dr. and Mrs. Castle, Dr. and Mrs. Cobb, and Dr. and Mrs. Cope. Dr. Burwell, who was Dean during our four years at HMS, spoke movingly of the past accomplishments of the School and thrilled us with his ever-youthful, confident vision of its future. A standing ovation to him was the highlight of the evening.

Fifty-nine members of the Class joined in the reunion festivities. For all, it was a nostalgic, happy return to scenes of remembered delights and a renewal of pleasant friendships. Numerous messages from members who were unable to be present were received and circulated. We took a brief moment to give thought to the ten members of our class who have died since graduation. The Class of 1941 takes quiet pride in the sacrifices made by its members in World War II.

On Alumni Day, the class was represented ably by the presentations of Perry

Culver and Carl Taylor. As chairman of the admission committee, Culver commanded rapt attention. Taylor made us all feel the importance of the challenge of worldwide public health needs and the stimulation of a career in this field.

President John Schilling presented a check for \$82,115 to Dr. Ebert. As Jack put it, this gift was a modest one when one considers our debt to the School. But it does make it possible, as Dr. Ebert said, for several students to attend HMS. This investment in the training of new professional manpower is most gratifying to the Class.

After a pleasant lunch in the tents on the Quadrangle, many of us listened to the symposium on the future of the Heart Disease, Cancer and Stroke program. We came away feeling that progress has been made in anticipating the impact of federal interest in the medical field. We realized, however, that much remains to be done to ensure that the planning for the use of federal funds and adjusting to federal influences will be appropriate, while preservingly the areas of excellence in medicine and medical education which have already been attained.

The dinner dance at the Country Club was delightful and most of the class attended. The dancing grew so strenuous that some members were in imminent danger of disarticulation at the lumbar spine, but all seemed to survive and not even Byrne had to have a back brace the next day. George Clowes' offer to take everyone sailing on Sunday was enthusiastically accepted by every member of the class. When he received the list of people who wanted to go sailing, his face paled only momentarily, and he



rallied rapidly to reassure everyone that all were welcome, even if they'd only be ballast.

On Saturday afternoon, most of the class made it to Curt and Daphne Prout's in Dover for a picnic lunch. Later in the afternoon, we went to George and Peggy Clowes' for the traditional clambake which was well lubricated by appropriate Harvard Alumnae reunion liquors.

Our 25th Reunion renewed our certainty that our class is unique in many ways. Not the least of which is that one of our members possesses what must surely be the most luxuriant red mustache in existence anywhere. With some confidence, we look forward to the 30th with the determination to make it at least that far.

This determination was bolstered Saturday afternoon. President Jack Schilling received a telegram from the redoubtable Class of 1916 who were solemnizing their 50th anniversary just a few miles away. The telegram read, "The 50th thanks the 25th for sustaining us through the evening. Hope you make it too." We replied, "The 25th appreciates your kind thoughts. We hope we make it through this evening, and to our 50th too."

## '46 ALEXANDER MACMILLAN

The Class of 1946 met for its 20th Reunion Friday night at the Charter House with a cocktail party, dinner, and dancing. Our class president, Jim Donald came from Colorado Springs, and Dave Solomon and Les Corsa made it all the way from California. We almost got Ed O'Rourke to come back from Bangkok and the USPHS but he could not make it.

As at our 15th reunion, it rained. But despite the weather, we gathered at Castle Hill in Ipswich for a wonderful afternoon and evening hosted by the Trustees of the Crane Estate. Tom Donovan and Don Flynn were pitching golf balls and Ike Manley down the fairway. After the clambake, Ken Ghormley, in from Redlands, Calif., and looking for specialists for his medical group, entertained us for hours at the piano.

We missed all those who could not make it. We agreed that we would return, along with those of us who were not present, for our next reunion, the 25th, in May of 1971.

Our special thanks to Dorothy Murphy for making this such an enjoyable reunion.



## '51 JOHN S. ROBEY

Despite Dorothy Murphy's rather dour prediction of a small turnout for a class as archaic as ours, 65 cheerful, mellowed classmates convened back at the ranch for our 15th Reunion. We were noted to congregate in the greatest numbers at the more dionysian aspects of the festive two days. Distance seemed no obstacle for such intrepids as Shep Ginandes from Hawaii, Lew Kraukauer from Oregon, Al Skinner from Washington, and many others from California, Florida, and all points between.

A dance was held in the animal room of the Harvard Club uninterrupted by lengthy speeches or business matters. On Saturday, to commemorate an equally enthusiastic reunion five years ago, a pleasant rain was noted by some; however, 85 persons enjoyed an old-time clambake at Jock and Alice Robey's decaying summer mansion at Annisquam with drinking and naughty jokes by Tuttle and Haynes that lasted well into the night.

## '56 ALAN D. PERLMUTTER

The 10th Reunion was enthusiastically celebrated by members of our Class who returned from locations throughout the United States. We were particularly happy to welcome classmates from California, Texas and Florida.

The elegant Commonwealth Room at the new Sheraton Boston Hotel was the scene of festivities on Friday evening. Following cocktails at the "free bar," 92 classmates, wives and guests enjoyed a roast beef dinner. Ruby Newman's

Orchestra provided sentimental strains for dancing, and an occasional "frug" for the young at heart. Highlight of the evening was the showing of class movies taken in 1956 by Walter Pahnke. Most classmates were still recognizable. Star of the film was Walter, doing acrobatics on the beach. Walter repeated his performance during this reunion, and his agility has been duly recorded for posterity. He plans to tumble again at our twenty-fifth.

John Davis, Hank Edmunds, Jack Greenberg, Jim McArthur and Charles Tashima all sent their regrets at being unable to attend.

The heavy rain on Saturday failed to discourage the enthusiastic 56ers who assembled during the afternoon at the Bass Rocks Beach Club in Gloucester, kindly made available to us by Howard and Ann Oakes. Roomy and informal, with an adjacent large tent, the Club was an ideal location for our outing. The optimism of the group was entirely justified as the rain stopped and the skies cleared in time for volleyball and softball on the beach, courtesy of John Grover Sporting Goods. The softball game ended at 14 to 10, although it is not clear who beat whom. No home runs were hit—no commentary necessary. With appetites thus sharpened, the group returned to the Club for a New England clambake, compete with steamers, lobsters, and corn on the cob.

Late Saturday evening, the Reunion concluded with nostalgic memories, sad goodbyes, and determined promises to meet again at our fifteenth.

## '61 LARRY G. SEIDL, JR.

The Class of 1961 claims a record in loyalty and spirit with one member returning to our 5th Reunion from far-off Mallorca, where it is said he was finishing Dr. Rutstein's preventive medicine paper! Others came from such distant territory as Providence, New York, New Haven, Cleveland, Charlottesville, the South End, the North Shore, and Fort Benning, Georgia. In all, 40 stalwarts of the Class were counted at the various activities of the 5th Reunion Whitsunday weekend. The hard facts of postgraduate training made for a somewhat different assortment of classmates at each of the events.

Alumni Day was warm and sunny, and

classmates gathered and stayed late at the tables nearest the traditional Black Label. The likewise traditional seafood newburg was replaced for all this year by Seiler's cold, sliced turkey through the intercession of Miss Murphy and the kindness of His Eminence, Cardinal Cushing. A few members were seen at the symposia, but by and large the returning alumni looked up old friends or looked over some of the additions to the New Boston.

That evening the weather remained inviting, and a congenial company of some 50 classmates, sweethearts and guests enjoyed cocktails, dancing to Ruby Newman's swinging orchestra, and

a sumptuous repast of roast beef tenderloin at the Charles River Boat Club in Cambridge. Imbibing, story-telling, and dancing were in vogue. A Mercedes 220 SL was noted in the parking lot along with all the VW's (the dentists clearly lead the prosperity parade for the present). Moonlight on the river could be viewed from the flower-decked porch. The frug was not observed on the dance floor, although there were orthopods on hand in the event of articular disaster. A radiologist was overheard to excuse his early departure because he had to be ready for an important golf tournament on Saturday. Our one returning member of the Green Berets exhibited a walking cast encasing a fractured tibia suffered in a practice parachute jump at Fort Benning. The rest of us counted our blessings and enjoyed other less vigorous yarns and a darn good party.

Class Day, five years later, was a bittersweet memory as once again the rain came pouring down all morning, postponing the afternoon softball match because of wet grounds. Dr. and Mrs. Earle Chapman saved the day by graciously opening the ballroom of their Brookline estate to a small but hardy band who gathered there for bird walks in the garden, still more tall tales, tasty barbecued chicken, and the inevitable cans of beer. Late in the afternoon, a frisbee appeared and was tossed about briefly, and finally, at Mrs. Chapman's invitation, numerous souvenir lilaes were guillotined from her heavily-laden bushes.

With one five year reunion down, we have only three more to go before our twenty-fifth—how times does fly.





# GLASS DAY 1966



It rained—not on a plain in Spain but in Boston, on Class Day 1966. But not even the inclement weather could dampen the spirit of the 141 graduates as they participated in the traditional Class Day exercises which were held in the Boston Latin School.

Fifteen members of the 177th class received honor awards for their work in the last four years. **Scott H. Nelson** was given the Harvard Medical Alumni Association Award "in recognition of his all-round ability and well-balanced personality." Dr. Nelson was president of the fourth year class and will be its permanent president. **Samuel Strober** was awarded the Leon Reznick Prize for "showing the most promise in research." The Henry Asbury Christian Prize "for diligence and notable scholarship" went to **Edward J. Pollack**. **Gilbert H. Daniels** received the Massachusetts Medical Society Prize for "the medical student who seemed most notably to have developed the intangible qualities of The Good Physician." The James Tolbert Shipley Prize for "research, the results of which have been published or accepted for publication" went to **David C. Dale**. **Robert A. Greenes** received the Borden Undergraduate Research Award in Medicine "for original research." The Moses Maimonides Prize of the Greater Boston Medical Society "for integrity, perseverance, courage and force of example" went to **Edwin H. Cassem**. The Boylston Medical Society Prizes "for excellence in medical dissertations" were awarded to **Joseph F. Scholand**, **Timothy E. Guiney**, and **Harold C. Sox**.

The Harvard School of Dental Medicine presented the following honor awards to its 97th graduating class. The Harvard Dental Alumni Gold Medal "for all-round scholastic excellence" went to **Robert M. Gracia**; the Harvard Dental Alumni Silver Medal to **James E. Mulvihill** who also received the Harvard Odontological Society Award "for the best senior student seminar"; the Grace Milliken Award "for the outstanding paper in the field of dental health" to **Lawrence M. Gettleman**; and the Dr. Norman B. Nesbett Medal "for excellence in the field of dentistry" to **Carlo L. Siegel**, **John M. Cotmore**, **Robert M. Gracia**, and **James E. Mulvihill** were named to membership in the Gamma Gamma Chapter of Omicron Kappa Upsilon, the national honorary dental society.

IN THINKING about my topic for today, it seemed particularly appropriate to paraphrase the opening paragraph from Dickens' *A Tale of Two Cities* for it captures the essence of contradiction in our culture today. At some future time a cultural anthropologist might describe us as follows:

It was the age of war and nuclear destruction; it was the age of peaceful co-existence and world government; it was a soulless epoch concerned only with material things; it was a compassionate epoch with deep concern for the individual; it was a time of lost identity and quiet despair; it was the moment of greatest creative opportunity; it was the

day of the platitude and slogan; it was the day of scientific truth; it was a contented era of mechanized mediocrity; it was a restless era seeking new peaks of excellence; it was an age of contradiction; it was an age of controversy.

This is a poor substitute for the words of Charles Dickens but the point is that every age that is experiencing great change is also an age of great contradiction, and it is this basic fact which provides the challenge. We are in the midst of the greatest social revolution in the history of mankind, one which is the inevitable consequence of the simultaneous revolution in science and technology. It is inconceivable that this could be a quiet, comfortable, placid

time, just as it is impossible for it to be a particularly consistent time. Neither our philosophies nor our social institutions can adapt rapidly enough to the products of scientific and social ferment. An age which uses the engineering miracle of *Teletype* to transmit a grade B soap opera might be said to be fumbling a bit with a statement of mission.

It is not the purpose of this talk to examine all of the world's problems but rather to state that medicine as a science, and medicine as a social institution, is a part of this great scientific and social revolution and provides its share of contradictions. I have heard doctors say, "I would not like my son to go into medicine because medicine is changing and will not be the same tomorrow as it is today." Quite right—it is changing and will change more, but this seems to me a reason for entering the profession rather than avoiding it. If the course of medicine were perfectly charted, it would provide little challenge for the imaginative or adventurous spirit.

There are, I am told, some minor grumblings from time to time about the Harvard Medical School curriculum, and it has even been suggested that it contains some inconsistencies and irrelevancies. Of course I find this hard to believe and even harder to believe that in a time of great social upheaval that the Harvard Medical School should change. Something must remain the same!

In a more serious vein let me speak for a moment about your preparation for the challenge that lies ahead. You have an unusual opportunity, and indeed an unusual responsibility, to respond to this challenge. My reasons for saying this are quite simple. You are a highly selected group, and in a sense you have already attained success—at least academic success. And despite the formality of the Medical School curriculum, you have had the opportunity to listen to, speak with and even argue with some of the most gifted scientists and physicians gathered together on one faculty. The fact is you really have no choice—you must respond to one or another challenge in medicine, and it only becomes a matter of which one.

**F**IRST of all there is the enormous challenge of individual accomplishment in the practice of medicine or in the science of medicine. Here the list of opportunities is so great that it would be tiresome to recite it. Curiously, the choice of a particular field may be as

# *The Challenge*

*by Dean Ebert*



much accident as design, but whatever the branch of medicine, the challenge of excellence is always there. No subject in medicine is inherently less interesting than any other; it is only people who have made it appear so. Be less swayed by the fashion of the moment than by the interest of the problem and the potential for contribution. The problem is not so much one of being a success or failure; it is rather the choice between the bold chance versus the safe one. Too often today there seems to be a pattern of training which for the moment appears to be the most popular and the safest. But it may not be the best for you. As you decide what it is you wish to do, also decide for yourself what preparation will be most profitable for you.

Some of you will wish to pursue careers in academic medicine and will become increasingly involved in medical research. There is one danger (among many) which I should like to warn you about. The pattern of research support today reflects a pre-occupation with projects which can be defined easily in research grant applications and quick results which can be summarized easily in progress reports. There is the inevitable temptation to choose the more superficial and "safer project" and to avoid the more interesting but more risky long-term problem. I hope you will take the chance whenever possible, and I hope that you will use your influence on the granting agencies to support people rather than projects.

Those of you who go into practice will face another kind of challenge besides the one of individual excellence. This is the challenge of changing patterns of medical care brought about by the manpower shortage; the complexity of modern medicine; the need to redefine the use we make of hospitals and of other people in the health professions; the challenge of a new kind of medical technology; and the need to use physicians efficiently and effectively. It is your responsibility not to passively resist these changes, but to participate creatively in the formulation of change so that innovation is possible while preserving the best of medical traditions.

There is a challenge which will face you whether you become a practitioner, a medical scientist or teacher, and this involves the relationship of medicine to the Federal Government.

Remember that Federal legislation reflects public need and public expectation. I hope you will help shape such legisla-

tion so that its ends can be accomplished and you will not blindly resist all social legislation as categorically bad.

No problem is solved without creating new problems, and the very success of medicine has contributed to the problems of our society. With a lowered mortality rate, we have created the problem of population control; with the preservation of the physical health of the elderly we have created the social problem of the old person.

Finally, there is the challenge of medicine as an instrument of foreign policy. War is an obsolete instrument of aggression. Perhaps our aggressive traits can be sublimated into more useful channels. We can do much if we are wise

enough not to try to reproduce our own image everywhere we go.

You will recall enough of *Alice's Adventures in Wonderland* to remember her meeting with the Cheshire Cat. Alice was hopelessly lost and was happy to ask, "Cheshire Puss . . . would you tell me please which way I ought to go from here?"

"That depends a great deal on where you want to get to," said the Cat.

"I don't much care where," said Alice.

"Then it doesn't matter which way you go," said the Cat.

". . . so long as I get somewhere," said Alice.

"Oh, you're sure to do that," said the Cat, "if you only walk long enough."



# *Life and Death*

**W**E HAVE come a long way. Four years ago we were college graduates. Suddenly we were medical students, casting suspicious glances at the vaguely reminiscent shapes under blue denim coverings as we entered the anatomy lab for the first time. In just a few minutes when we repeat the Hippocratic Oath, we shall be doctors. Then with just one mouth to savor that role in peace and quiet, the "real world" will envelop us again and we will be interns.

What have we accomplished during these four hectic years at medical school? First, and perhaps foremost, we have become collectors of facts. Our vocabularies have soared astronomically from years of accumulating and stockpiling the multitude of organized facts that constitute the science of medicine, and the more nebulous body of knowledge that constitutes the art of medicine. We have skirmished with Gray's, Bard, Cecil and Loeb, and one huge neuropathology syllabus, and they are ours. We have had

an academic banquet, with the world's foremost chefs serving us the main courses. In a way we have become extremely well-programmed computers, capable at a moment's notice of disgorging formidable lists of signs and symptoms. And we have all begun to gather master's points in the popular game of differential diagnosis.

Medical school has also been a time of broadening interests. It is paradoxical how, in the midst of more restriction and requirements than we had ever faced before, at a time when hours of classes became transformed into months on duty, we became aware of a world taller, wider, and deeper than the one in which we had previously existed. Gross anatomy became microscopic and submicroscopic anatomy; the human being dissociated into organ systems, then tissues, then into enzyme groups and the genetic material itself, only to be wondrously transformed into a functioning living thing again.

The Medical School has also been us—the Class of 1966. We are essentially the same group that heard our accomplishments and characteristics summarized by Dr. Gardella in Building C four years ago. But we weren't really a class then and we are now. We have lived and worked with each other, and in a rare instance, even married each other. At various times our classmates have taken up the piano, trombone, clarinet, guitar, flute, violin, and, briefly, the bagpipes. Our friendships, like all others, have been varied—some iron-clad, some ephemeral. But most of all we have been together, have grown together, and are here together now—no mean accomplishment.

**W**E HAVE BEEN eminently successful in three major areas during our years at medical school; in our acquisition of facts, in our increasing awareness of what comprises medicine, and in our growth through association with one another. This success moved a previous Class Day speaker to conclude his address with lines from Walt Whitman:

Oh Captain, my Captain!  
Our fearful trip is done!  
The ship has weather'd every rack,  
The prize we sought is won.

The question is, have we already won "the prize?" We live in a badly disordered world where progress in a war must be measured in certified body counts, and where some men are about to land on the moon while others are still earning the right to vote. Can even an élite group of medical students, destined to become élite physicians, claim to have succeeded already in such an era? Of course not! We have acquired knowledge with a vengeance, but it remains for us to achieve wisdom. In the same way, our conscious world has expanded enormously, but unless we obtain the proper perspective towards new fields, we may find that we have grown up in this world, only to grow away from it.

Even as we graduate from medical school we are applying for admission to our profession. It is a rapidly changing profession in an even more volatile world. It is up to us to take the qualifica-



# by Jay Kaufman '66

tions and set them to work to build our careers properly. We have had the immense privilege of a Harvard Medical education and now we must place this education into perspective where it will stand as a vehicle rather than a goal, and as an influence rather than an order. A medical school, no matter how great, is still just medical school. Our task must be to reshape our lives wisely lest we become frozen in the mold which has shaped us to this point. If there are 141 of us in this graduating class, then there are 141 different lives for us to lead, and 141 different tasks for us to accomplish. Each one of these lives, and each one of these tasks should bear the special stamp of the individual as much as it reflects the common set of ideals that Harvard presented to us in our years together. If we have been selected to receive a degree from this school, let us honor this school's name by ignoring her precepts when our own drummer sounds a louder

march. We are destined to create roles rather than to fit into them.

For those of us who intend to concentrate on research, this means having the courage to investigate entirely new subjects rather than concentrating on fragments of well-worn ideas. For those of us who will teach, this means asserting the importance of the educator as an equal partner in medical affairs and an honored member of the academic community. For all of us this means a renewed interest in the patient. Incredibly, of all the different facets of medicine, it is the patient-doctor relationship which suffers most from inattention during these beginning years. Yet medicine in the future, like medicine in the past, will be oriented toward the patient, not the physician. The wisdom of medicine derives from the doctor's contact with the patient under his care, and all of medicine's many worlds revolve around the illness of the individual.

Responding to the patient is the most difficult task that we have yet to face. On the one hand, the enormity of realities such as death almost force the physician to respond by depersonalizing his approach, just as he finds euphemisms to denote the act of dying. Yet on the other hand the routineness of suffering and disease can lead all too easily to ignoring their importance. We all know what Francis Weld Peabody said about the care of the patient, yet few of us *think* about what he said.

I thought twice before ending my address with a quote, for fear that some future speaker might use it against me. But I was too drawn to the words of Robert Frost to ignore them, for in a little over a month we may find that his symbolic words have come true:

The woods are lovely, dark and deep,  
But I have promises to keep  
And miles to go before I sleep,  
And miles to go before I sleep.





"Sand dunes have a fascination all their own. In the multiplicity of their forms and colors, varying with the seasons and years, they are a constant source of pleasure, while in their wealth of plant and animal life their interest is never ending. The beauty of the sand dunes is revealed at every turn, their secrets are legion. The course of their formation from the time they emerge out of the sea as reefs marked by every tide, until they have reached perfection in their wavelike crests fifty feet high is an absorbing study. While the beach grass is beautiful in mass, the individual clumps and sprays of graceful upright and drooping grass stems, and rigid plumes of flower and fruit are exceedingly picturesque in their brilliant white setting of sand. Around each clump is often drawn a magic circle, a fairy ring, for the drooping grass blade, blown by the wind, writes with its tip in the soft sand."



# Windrows and Wrack

by George E. Gifford, Jr., M.D.

GREAT NATURE WRITERS have certain places forever associated with their names. Selbourne is linked to the gentle naturalist-priest, Gilbert White; Walden Pond is Thoreau's; Yosemite Valley is the province of John Muir; Cape Cod has been chronicled by Thoreau, and more recently in *The House on Nauset Marsh* by Wyman Richardson (1955) and *The Outermost House* by Henry Beston (1928). The Ipswich dunes and salt marshes of Massachusetts were masterfully described in two books, *Sand Dunes and Salt Marshes* (1913) and *Beach Grass* (1923) by Charles Wendell Townsend

M.D. (1859-1934).

Why did Townsend, who was at the turn of the century, "one of Boston's most skilled obstetricians and an authority on the nutrition of children," turn to the dunes and marshes? As a freshman in Harvard College, he became a member of the then recently organized Nuttall Ornithological Club, now the oldest ornithology group in the United States. Townsend was elected to the Club the same year as young Theodore Roosevelt and they both came under the influence of the great ornithologist, William Brewster.



On graduation from Harvard in 1881, Townsend turned naturally to the study of medicine, for the profession was traditional on his father's side of the family. His grandfather, Solomon Davis Townsend, was a surgeon and his great-grandfather, David Townsend, was a well known surgeon during the American Revolution. After graduation from Harvard Medical School in 1885, medicine occupied Townsend's entire attention. He was assistant in obstetrics at Harvard Medical School from 1887-1897, physician to the out patient department of the Children's Hospital from 1887-1903, the Boston Lying-In Hospital from 1887-1898 and the Massachusetts General Hospital from 1891-1909.

His scientific works from this period are: *Chlorosis with special reference to its treatment by intestinal antiseptics* (1896) and *Puerperal eclampsia: a study of one hundred and sixty cases occurring at the Boston Lying-In Hospital and in the private practice of members of the Obstetrical Society of Boston* (1897).

From 1917 until he died in 1934, Townsend was director of the Massachusetts Audubon Society; vice-president of the Nuttall Ornithological Club from 1912-1925; Fellow of the American Ornithologists Union and

a member of Phi Beta Kappa (hon.) 1928.

**A**ROUND 1892, ATTRACTED by the natural beauty of Ipswich, he built a summer house on a ridge overlooking a wide expanse of salt marsh, beyond which lay the white sands and green beach grass of the dunes, with open sea to the eastward. It was then that Townsend began his observations and studies of the Ipswich dunes and marshes. As Townsend wrote in the preface to *Sand Dunes and Salt Marshes*, "For the last twenty years I have spent most of my summer vacations at Ipswich and have made brief visits there as often as I could at other seasons, while almost twenty years before that the birds of this Massachusetts coast began to claim my attention. The opportunities for study are large in these regions, and my excuse for not having gone deeper in all these years, is that I have been of necessity a brief bird-of-passage in the dunes and marshes; but even with visits of a day's duration one can in time cover every date in the calendar."

While tramping over the hills, along the beach, or through the dunes, boating or swimming in the broad tidal creek close at hand, enjoying clam bakes on the beach, or picnics on the nearby hills, his

quick eye was keen to detect the characteristic marks of water and shore birds in their spring and autumn passages. With increasing enthusiasm he devoted himself to field observations at every opportunity.

In those days, there were no popular books on bird identification and binoculars had not been invented. Townsend always carried a small memorandum book with detachable leaves in which he made his record of birds seen on each trip. These pages were later filed in small envelopes, one for each species, arranged in a card catalogue box. As an outgrowth of the Ipswich experiences, he published in 1905 his *Birds of Essex County*.

In the summer of 1906 he made a trip along the coast of Labrador with Clover M. Allen. A colorful and charming account of the coast, its people and bird life was chronicled in his book, *Along the Labrador Coast* (1907). Three years later he undertook a second visit, this time starting early in the season in order to be in time for the beginning of spring in southern Labrador. He again recorded his trip in book form, *A Labrador Spring*. In 1911 he prepared an abridged and annotated edition of Captain's Cartwright's *Journal*, which had been kept during an



*"There is a restful and satisfying character in marsh views which grows with acquaintance. One never tires of them, perhaps because they are never the same, and because they are even more changeful than the restless sea. Looking out on the broad bosom of the marshes one cannot be lonely, the sense of their beauty is in the heart."*

"In many places the hay is piled in huge stacks, that are elevated above the highest tides on small piles or 'staddles,' as they are called, and the stacks dot the marsh for miles like clustered tents. When the marsh is fast bound by winter frost the farmer goes his rounds and carries off the savory, salty hay on sledges, his horses' iron shoes now well sharpened. No need of wooden marsh shoes; all is hard and solid as the rocky ledges."



attempt to settle on Labrador, and was first published in 1792.

Townsend was a most capable photographer. Of course, photography was no casual hobby in those days. Photographic film was unknown and it was necessary to develop the glass plates yourself and also make the prints. Few darkroom conveniences were at hand, nor were electric lights available. But Townsend took excellent pictures and he selected his subjects with care. Most of the illustrations in his books were made from his own photographs.

Ipswich was Townsend's first and foremost interest. The Ipswich region is unique in its combination of varied land and water conditions. The low rounded hills of glacial grounds were long ago turned into pastures by the early settlers. The ancient forests were cut and the wide stretches of open fields, vast salt marshes, and the distant sea all give the feeling of great space. The Ipswich and Essex Rivers cut through the rolling hills. The long barrier beach of white sand fronting the sea protects the broad salt marshes with their muddy creeks and abundant growth of marsh grass on the flats. Such an area is never still. The tidal creeks fill twice daily, flooding the expanse of marsh. The wind is ever blow-

ing the shifting sand, and the restless sea pulls down and builds up the shore.

In this meeting place of elemental forces, Townsend took keen interest. He was familiar with the place at all times of the year and under all conditions. On weekends in autumn, winter and spring, often with one or two companions, he would escape from the city to Ipswich. Whatever the weather, rain, shine or snow, the long tramp across fields and byways from the train station brought him to the hospitable shelter of his cottage, *Merula Farm*. The stove was soon going, supper eaten, and then to bed for an early start in the morning, often on winter nights with a hot brick wrapped in a cloth for a bed companion. Sunrise would find him cooking a camper's breakfast, ready for a forenoon tramp through the dunes.

These Ipswich experiences are the gist of his two finest books—*Sand Dunes and Salt Marshes* and *Beach Grass*. To read them is to feel, smell and see the area. His more technical observations of birds were published in his *Supplement to the Birds of Essex County* (1920).

After Dr. Townsend's wife died in 1917, he retired from active practice and moved to Ipswich "year-round." In 1925 he followed Audubon's epic journey

down the Ohio and Mississippi Rivers, visiting many southern cities. In 1926 and 1927 he made a journey by steamer around the world, stopping at the Hawaiian Islands, Japan, China, Java and Ceylon. The following year he traveled through the Panama Canal, down the west coast of South America, around Cape Horn and up the coast line on the Atlantic side of the continent. His impressions of this journey are embodied in *From Panama to Patagonia* (1931). In 1931-1932 he toured around the African continent, stopping at various tourist points on the Mediterranean and East African coast, occasionally making side excursions inland.

**A** GOOD STORY ABOUT Townsend is told by author Wyman Richardson:

"I well remember an argument at the Nuttall Club that took years to settle. At one of the meetings a young member rather casually asked if rabbits could sing. Dr. Townsend immediately pointed out that rabbits could thump, whistle and squeal but could not sing.

"The president of the Club, the late Dr. Glover M. Allen, then somewhat facetiously remarked that there were reports from Australia of rabbits becoming carnivorous and starting to make singing

noises (reports that later proved to be croneous). President Allen suggested that perhaps the rabbits referred to had taken to eating young terns. But Dr. Townsend would not be put aside.

"What was the song like?" he wanted to know.

"Mm, mmmm-mmm-mmm-mm," said the young man.

"Why that's the song of the Leach's Petrel!" exclaimed the doctor. (Leach's Petrel had not then been known to nest west of the Maine coast.)

"The young man smiled. 'We watched the hole for hours and finally a rabbit came out. So we decided it was the rabbit that was making the noise.'

"Dr. Townsend was not convinced. A committee to investigate the matter was appointed and, at the club's expense, spent several days of the following July on Penikese Island. The report was the same. 'Mm, mmmmm-mm, mmm-mm,' from the hole. Rabbits came out, no singing; rabbits came back, singing.

"I don't care," said the Doctor, "that's the song of the Leach's Petrel. I move that another committee be appointed and I ask to be made a member of it."

"This was done. Rabbits came out, no singing; rabbits came back, singing. But

this time, owing to the Doctor's persistence, the watchers waited. And sure enough! A short time before sunrise a pair of Leach's Petrels came out of the same rabbit hole. Thus was established the record of the western-most nesting site of this petrel, and once more Townsend's reputation for accurate observation (as well as obstinacy) was enhanced."

In *The New York Times Book Review*, April 10, 1966, Walter Teller said:

"Good nature writing is hard to come by. So is good-natured writing, and these two things may not be unrelated. A rising tide of urbanization produces little of either. Nor does accelerating mobility. The first-rate writer on nature is not chasing the sun or the season. Instead, he localizes. He summons forth the sense of locality, the genius and gist of a particular place. He evokes its peculiar characteristics."

By this definition Townsend was a good nature writer—he evoked the genius and gist of Ipswich.

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"Although many of the swallows scatter far and wide in the search for food, yet such is the social disposition of these birds that great flocks are commonly to be found during July, August and early September, even at midday in various of their favorite haunts. Perhaps the most familiar of these haunts, and certainly the most conspicuous to the passer-by, is the roadside. Here they congregate and line fence rails and telegraph wires. One may see lines of these birds stretching with but a few gaps, on a couple of wires for a mile. Such congregations number several thousand, and all four species may be seen sitting shoulder to shoulder in the most friendly and democratic manner."

*This article is dedicated to Francis C. Wade of Ipswich, who, like Charles Wendell Townsend, has been a "bird of passage" in the salt marshes and sand dunes.*



# No TIME FOR REST

by

**Robert Cutler**



Recalling a crowded, private and public life, General Cutler has written an extraordinarily interesting memoir of seventy years. Lawyer, banker, Presidential Assistant, humanitarian, intimate with Secretary Stimson, General Marshall, James Forrestal and General Eisenhower—his story is an illuminating footnote to history. General Cutler has been a trustee of the Peter Bent Brigham Hospital for 30 years, a Vice-President of the Harvard Medical Center since its founding in 1956, and is the surviving brother of Dr. Elliott C. Cutler, formerly Moseley Professor of Surgery at the Harvard Medical School and Surgeon-in-Chief at the Brigham Hospital. As Dr. George P. Berry, former dean of Harvard Medical School, said: "No one has surpassed General Cutler in the zeal and effectiveness by which he has worked to strengthen the Harvard Medical School and the Associated Teaching Hospitals. Indeed, he was one of the architects of the Harvard Medical Center. Without his magnificent help, many of the resources indispensable to the forward thrust of Harvard Medicine could not have been attained."

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ATLANTIC-LITTLE, BROWN

Boston, Massachusetts

# SPEECHES WE'VE HEARD BEFORE

## Or, the OVERDONE cliché



Mr. Chairman, President Smith, Members and Guests: *I apologize for rising again<sup>1</sup> but I would be most remiss if I were to allow Dr. Jones' most interesting and provocative paper to go undiscussed.<sup>2</sup>*

As we visualize the *explosion of medical knowledge* we must *come to grips<sup>3</sup>* with the realization that *from the well-spring of learning* offered by our modern medical schools will come *a rich and meaningful experience<sup>4</sup>* for each student.

More than this, in the recent past, *not infrequently<sup>5</sup>* many of us have had the advantage of sharing an *on-going, broadening medical experience*, that touches on many of the *broad parameters of medical discipline* and leaves us aware of the *scientific continuum* that is so much a part of learning.

The resulting *image of medicine*, as it attempts to foster the *advancement of science*, will, in a larger sense,<sup>6</sup> find its *best articulation* in the broadening scope of *community care*.

Based upon a *not inconsiderable experience<sup>7</sup>* with this problem, it would not be *inappropriate<sup>8</sup>* if I directed my attention to the subject for a few brief moments.

*I don't want to prolong unduly the discussion,<sup>9</sup> but I feel compelled to emphasize* what I consider *our role in medicine* to be in order that *academic excellence be maintained*.

*Again I apologize for rising, and wish to thank the society for the privilege of the floor.<sup>10</sup>*

1. The speaker really does not mean to apologize for rising. He is getting up because he wants to verbalize, and likes the feeling of power the rostrum gives him.

2. Actually, nobody was provoked.

3. It is not a wrestling match.

4. "Rich," maybe, if you believe what people say about medicine.

5. The sly negative has common usage.

6. "Larger sense" implies louder, more odor, brighter.

7. 8. More negatives.

9. What is actually the case here is that the speaker may well run on for some time.

10. Nobody actually gave him the floor.

# ALONG THE PERIMETER

## 1966 Appointments

LEWIS L. ENGEL, professor of biological chemistry

KURT J. ISSELBACHER '50, professor of medicine at Massachusetts General Hospital

PAUL GOLDHABER, professor of periodontology

JEAN-PAUL REVEL, associate professor of anatomy

ALFRED KRANES '30, clinical professor of medicine

WYLAND F. LEADBETTER, clinical professor of surgery

HARRY SHWACHMAN, clinical professor of pediatrics

DANIEL ABRAMSON '28, associate clinical professor of obstetrics and gynecology

RICHARD B. COHEN, associate clinical professor of pathology

CHARLES L. EASTERDAY '49, associate clinical professor of obstetrics and gynecology

CHARLES M. FISHER, associate clinical professor of neurology

AGNES B. RUSSFIELD, associate clinical professor of pathology

JOHN G. SCANNELL '40, associate clinical professor of surgery

ROBERT M. SMITH '38, associate clinical professor of anesthesia

PAUL A. YOUNG '31, associate clinical professor of gynecology

DAVID W. ALLEN '54, assistant professor of medicine

DAVID T. ARMSTRONG, assistant professor of anatomy in the Harvard School of Dental Medicine

DEWITT C. BALDWIN, JR., assistant professor of pediatrics at Forsyth Dental Center

NORMAN W. BELL, assistant professor of sociology in the department of psychiatry at McLean Hospital

SAMUEL R. CAPLAN, assistant professor of biophysics

THEODORE COLTON, assistant professor of biostatistics in the department of preventive medicine

MARGARET F. CONROY, assistant professor of mathematical biology in the department of medicine

JOHN E. CRAIGHEAD, assistant professor of pathology

JOHN DAVID, assistant professor of medicine at Robert Breck Brigham Hospital

PIERRE M. DREYFUS, assistant professor of neurology at Massachusetts General Hospital

DONALD T. DUBIN, assistant professor of bacteriology and immunology

MARY L. EFRON '51, assistant professor of neuropathology at Massachusetts General Hospital

MARTIN H. FLAX, assistant professor of pathology at Massachusetts General Hospital

IRWIN M. FREEDBERG '56, assistant professor of dermatology at Beth Israel Hospital

HOWARD GOLDFINE, assistant professor of bacteriology and immunology

HENRY M. GOODMAN, assistant professor of physiology

PAUL G. HUGENHOLTZ, assistant professor of pediatrics at The Children's Hospital

JOHN W. LITTLEFIELD '47, assistant professor of pediatrics at Massachusetts General Hospital

FARAHE MALOOF, assistant professor of medicine at Massachusetts General Hospital

ROBERT G. MONROE, assistant professor of pediatrics at The Children's Hospital

DAVID G. NATHAN '55, assistant professor of pediatrics at The Children's Hospital

FRED S. ROSEN, assistant professor of pediatrics at The Children's Hospital

BERNARDO A. SANTAMARINA, assistant professor of obstetrics and gynecology

DAVID SHAPIRO, assistant professor of psychology in the department of psychiatry

ROBERT G. SPIRO, assistant professor of biological chemistry at Peter Bent Brigham Hospital

ALAN A. STONE, assistant professor of psychiatry at McLean Hospital

ARMEN H. TASHJIAN, Jr. '57, assistant professor of pharmacology in the Harvard School of Dental Medicine

HENRY DE F. WEBSTER '52, assistant professor of neuropathology at Massachusetts General Hospital

RICHARD E. WILSON, assistant professor of surgery

WILLIAM F. BERNHARD, assistant clinical professor of surgery

JOHN F. BURKE '51, assistant clinical professor of surgery

ALLEN C. CROCKER '48, assistant clinical professor of pediatrics

JACK R. DREYFUSS, assistant clinical professor of radiology

SHIRLEY G. DRISCOLL, assistant clinical professor of pathology

HENRY D. EPSTEIN '40, assistant clinical professor of periodontology

DONALD C. FYLER '48, assistant clinical professor of pediatrics

WILLIAM H. HARRIS, assistant clinical professor of orthopedic surgery

JOHN G. HARTER '53, assistant clinical professor of medicine

JOHN F. JEWETT '38, assistant clinical professor of obstetrics and gynecology

MYRON B. LAVER, assistant clinical professor of anesthesia

WILLIAM J. MULLIGAN, assistant clinical professor of obstetrics and gynecology

ALBERT E. SLOANE, assistant clinical professor of ophthalmology

TAYLOR R. SMITH, assistant clinical professor of ophthalmology

JOEL J. ALPERT '56, associate in pediatrics

THOMAS P. ASHFORD, associate in pathology at Beth Israel Hospital

JOSEPH M. CORSON, associate in pathology

FRANK F. DAVIDOFF, associate in medicine at Beth Israel Hospital

GEORGE T. DIAMANDOPOULOS, associate in pathology

WOLFGANG EPSTEIN, associate in biophysics

HOSSEIN D. FAHIMI, associate in pathology

SID GILMAN, associate in neurology

GARETH M. GREEN '57, associate in medicine

IRENE JAKAB, associate in psychiatry at McLean Hospital

ARTHUR A. LIKE, associate in pathology

RICHARD LONGABAUGH, associate in social psychology in the department of psychiatry at McLean Hospital  
CHAIM I. MAYMAN, associate in neurology at Beth Israel Hospital  
NORBETT L. MINTZ, associate in psychology in the department of psychiatry at McLean Hospital  
JOHN C. NORMAN '54, associate in surgery  
DONALD E. OKEN, associate in medicine at Peter Bent Brigham Hospital  
DWIGHT R. ROBINSON, associate in medicine at Massachusetts General Hospital  
ASCANIO M. ROSSI, associate in psychology in the department of psychiatry  
STEPHEN S. ROTHMAN, associate in physiology in the Harvard School of Dental Medicine  
SEYMOUR M. SABESIN, associate in medicine at Massachusetts General Hospital  
STUART F. SCHLOSSMAN, associate in medicine at Beth Israel Hospital  
GEOFFREY W. G. SHARP, associate in pharmacology at Massachusetts General Hospital  
DAVID H. SMITH, associate in pediatrics  
PHILIP R. STEINMETZ, associate in medicine at Beth Israel Hospital  
MARY L. STEPHENSON, associate in biological chemistry in the department of medicine  
KENNETH A. WOEBER, associate in medicine  
HUBERT J. WOLFE, associate in pathology at Massachusetts General Hospital  
THOMAS B. BRAZELTON, clinical associate in pediatrics  
HENRY BROWN, clinical associate in surgery

NATHAN P. COUCH '54, clinical associate in surgery  
ROMAN W. DESANTIS '55, clinical associate in medicine  
JEROME W. FISCHBEIN '51, clinical associate in medicine  
NORTON FISHMAN '54, clinical associate in prosthetic dentistry  
GERALD S. FOSTER '51, associate in medicine  
HAROLD S. GOLD '55, clinical associate in prosthetic dentistry  
PAUL P. GRIFFIN, clinical associate in orthopedic surgery  
GEORGE B. C. HARRIS, clinical associate in radiology  
EMANUEL S. HELLMAN '57, clinical associate in medicine  
MERLE A. LEGG, clinical associate in pathology  
ANNA T. MITUS, clinical associate in pediatrics  
ANTHONY P. MONACO '56, clinical associate in surgery  
RICHARD NESSON, clinical associate in medicine  
PAUL F. J. NEW, clinical associate in radiology  
THOMAS F. O'BRIEN '54, clinical associate in medicine  
EDMUND C. PAYNE, JR., clinical associate in psychiatry  
DONALD S. PIERCE '57, clinical associate in orthopedic surgery  
GERALD R. PLOTKIN, clinical associate in medicine  
KEITH R. RABINOV, clinical associate in radiology  
GUILLERMO C. SANCHEZ '49, clinical associate in medicine  
CHARLES A. SANDERS, clinical associate in medicine  
ARTHUR A. SASAHARA, clinical associate in medicine  
WILLIAM D. SOHIER, JR. '46, clinical associate in medicine  
ARNOLD STARR, clinical associate in surgery  
NORMAN S. STEARNS, clinical associate in medicine  
DAVID R. M. VAN PRAAGH, clinical associate in pathology  
GEORGE E. FOLEY, lecturer on pathology  
FRANCIS L. A. DEMARNEFFE, lecturer on psychiatry  
JOHN GARCIA, lecturer on psychology in the department of surgery  
JOHN KOSA, lecturer on sociology in the department of pediatrics

## Architect of Countway Library Receives Award

The Countway Library and its architect, Hugh Stubbins & Associates have received the Award of Merit "in recognition of distinguished accomplishment in Library architecture" from the American Institute of Architects in cooperation with the American Library Association and the National Book Committee, Inc. Presenting the award in ceremonies at the Library is Mr. Norman Fletcher (third from right) of The Architects Collaborative, and president of the Boston Chapter, American Institute of Architects. Participating in the ceremonies (l. to r.) were: Dean Robert H. Ebert; Mr. Ralph T. Esterquest, Librarian; Mr. Hugh A. Stubbins; Mr. Fletcher; Dr. Howard Sprague, president, Board of Trustees, Boston Medical Library; and Dr. George P. Berry.





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## HMAA Elections

Chester M. Jones '19 became president of the Harvard Medical Alumni Association during the annual business meeting on May 27, 1966. Wesley W. Spink '32 was named president-elect of the Association. The retiring president is John D. Stewart '28.

Elected to three-year terms as members of the Association's Council were Claude E. Welch '32, Joseph Stokes, 3d '49, and William R. Waddell '43B. Thomas B. Quigley '33 was elected to a two-year term as the Association's representative to the Associated Harvard Alumni.



*Dr. Rabkin*

## New Appointments At Cambridge City

The third link in a lengthening professional relationship between the Harvard Medical School and the Cambridge City Hospital is the appointment of Richard Warren '34, clinical professor of surgery at Harvard, as chief of surgery at the Cambridge City Hospital. Dr. Warren's appointment is made through Harvard's department of surgery at the Boston City Hospital.

Dr. Warren has been associated with Harvard Medical School since 1939. He has long been active in the surgical affairs of the Veterans Administration and was chief of surgery at the West Roxbury Veterans Administration Hospital. At present he is chief of the General Surgery Section in the V.A.'s central offices in Washington. His principal interest is in the clinical and investigative aspects of cardiology.

Also announced by Dr. Ebert and Mr. Theodore A. Austin, director of the Hospital, were the appointments of Francis M. Woods and Alan R. Speivack '59. Dr. Woods, clinical associate in surgery, has been named associate chief of the surgical service and chief of thoracic surgery at Cambridge City hospital. Dr. Speivack, instructor in surgery, has been appointed assistant chief of the Hospital's surgical service.

Harvard Medical School and Cambridge City Hospital hope to establish future relationships in the areas of obstetrics and gynecology, anesthesiology, and pathology.

## Rabkin Heads BIH

Mitchell T. Rabkin '55 is the new administrative director of the Beth Israel Hospital, Boston. Dr. Rabkin is instructor in medicine at Harvard Medical School and acting chief of the endocrine clinic at the Massachusetts General Hospital. He succeeds Sidney S. Lee who, on July 1, became associate dean for hospital programs at Harvard Medical School.

Dr. Rabkin took his internship and residency at the Massachusetts General Hospital after which he was appointed clinical associate at the National Institute of Arthritis and Metabolic Diseases. Upon his return from Bethesda, he became chief medical resident at MGH. At present, he is junior visiting physician at Boston Veterans Administration Hospital.

## Dr. Rutstein Receives Swedish Medal



David D. Rutstein '34 received the Jubilee Medal from the Swedish Medical Society on April 19, 1966. The Medal was struck in the King's Mint to commemorate the Society's sesquicentennial anniversary. The inscription reads: "To science's advancement through mutual communication of knowledge and collected experience." At left is the reverse side of the medal with the inscription: "To the furthering of friendly confidence between doctors."

## Three HMS Alumni Embark on Deanships

Across the country, from Massachusetts to California, nine Harvard Medical School graduates are Deans of medical schools. Last Spring three more Alumni joined these illustrious ranks and extended the boundaries southeast to Lebanon, north to New Hampshire and west to Cleveland. In March, John L. Wilson '39 became Dean of the Faculties of Medical Sciences at the University of Beirut; in May, Carleton B. Chapman '41 became Dean of Dartmouth Medical School and Frederick C. Robbins '40 became Dean of Western Reserve University School of Medicine.

From 1953-58, Dr. Wilson was professor of surgery at Beirut. In 1958 he returned to the U.S. to become chief of the surgical service at the U.S. Veterans Administration Hospital in San Francisco and associate clinical professor of surgery at the University of California School of Medicine. Since 1960 he has

been chairman of the department of surgery at the American University.

Dr. Wilson is certified by the American Board of Surgery and the Board of Thoracic Surgery. He is co-author of *A Handbook of Surgery*.

Until the Fall, when Dr. Chapman assumes his duties as Dean of Dartmouth Medical School, he will continue as professor of medicine at the University of Texas Southwestern Medical School and director of the Pauline and Adolph Weinberger Laboratory for Cardiovascular Research. Dr. Chapman's research and clinical interests are centered on the heart and circulation, with special emphasis on human exercise.

Dr. Chapman is a diplomate of the American Board of Internal Medicine and of its Cardiovascular Subspecialty Board. In 1963 he was awarded a Career Professorship by the National Institutes of Health. Dr. Chapman was president of

the American Heart Association in 1964.

Dr. Robbins is professor of pediatrics at Western Reserve and director of the department of pediatrics and contagious diseases at Cleveland Metropolitan General Hospital. He will become Dean of Western Reserve Sept. 1, 1966.

His research interests have focused on infectious hepatitis and typhus fever, the recognition and epidemiology of Q fever and the immunology of mumps. With Thomas H. Weller '40, Dr. Robbins won the first Mead Johnson Prize in 1953 for the application of tissue culture methods to the study of viral infections. One year later, with Professor John F. Enders and Dr. Weller, he received the Nobel Prize in medicine and physiology for discovering a practical method of growing the poliomyelitis virus in cultures of different tissues. This discovery opened the door for the production of the polio vaccine.

## Schizophrenia

The Faculty of Medicine has approved an administrative division of the Department of Neurology and Psychiatry into two separate units—a Department of Neurology and a Department of Psychiatry. Each Department will have its own courses and personnel and will be listed separately in the catalogue of the Medical School.

Since 1913, when the Department of Diseases of the Nervous System was formed, the two departments have been academically linked. In 1941, a vote of the Faculty changed the title to the Department of Neurology and Psychiatry.

Under the new arrangements, the Department of Neurology will continue to maintain academic departments at the Massachusetts General Hospital, the Boston City Hospital and Children's Hospital Medical Center. The Department of Psychiatry will maintain academic departments at the Massachusetts Mental Health Center and the Massachusetts General Hospital. The department at Massachusetts Mental Health Center includes teaching units at the Beth Israel Hospital, Peter Bent Brigham Hospital, Boston City Hospital and Children's Hospital Medical Center. The department at Massachusetts General Hospital includes a teaching unit at McLean Hospital.

## Diamond Receives Kennedy Award

Louis K. Diamond '27 received the Joseph P. Kennedy, Jr., Foundation International Award in Mental Retardation for Scientific Research in April.

Dr. Diamond, who is professor of pediatrics at Harvard Medical School, and associate physician-in-chief and head of the hematology division at Children's Hospital Medical Center, received the award for the treatment he developed in 1946 for performing blood exchange transfusion on Rh positive jaundiced and anemic babies of sensitized Rh negative mothers. Today, his technique of re-

moving incompatible blood and replacing it with compatible Rh negative blood is credited with having saved thousands of children all over the world from mental retardation, cerebral palsy, nerve deafness, and death.

"My interest in 'yellow babies' with anemia goes back to 1928," said Dr. Diamond, "when I was a house officer at Children's Hospital." During the next four years, he collected data from some 20 newborn "yellow babies" and, in 1932, he published the first comprehensive article on this disease complex that became known as Erythroblastosis Fetalis.

Approximately 10,000 babies are born yearly in the U.S. with Rh Disease. Prior to 1946, about 20 percent of all infants born with the disease died. Some 32 percent more suffered severe brain damage leading to mental retardation and cerebral palsy. If an Rh sensitized mother had a newborn with Rh positive blood, the odds were 50 percent that the infant would either die or have this crippling disability.

Today, only 10 out of every 500 babies born with Rh Disease die. Only seven out of 500 may have mental retardation which should be completely preventable in the future. The man chiefly responsible for these improvements is Dr. Diamond.



Dr. Diamond

## Mechanical Failure Significant Factor in Auto Fatalities

How old is your car? How often is your car inspected? How old are you? What is your economic status? Where do you live? The answers to these questions may be an important clue as to whether you are heading for an accident or not.

In April, an interesting hypothesis was offered to the American College of Physicians at the 47th annual session in New York, by two HMS investigators: Robert C. Buxbaum, M.D., instructor in preventive medicine at HMS, and Theodore Colton, Sc.D., assistant professor of biostatistics in the department of preventive medicine. They found, among other things, that the relationship between a lower death rate from car accidents and annual or semi-annual motor vehicle inspection gave rise to their hypothesis that mechanical failure may be a significant causative factor in automobile accident mortality. Their conclusions were based on an analysis of the death rates in 1960 when grouped by the presence or absence of motor vehicle inspection data.

Two automobile inspections per year were required by nine of the United States in 1960, while only eight other states required one inspection. Statistics for that same year, it was pointed out, showed that states which inspect vehicles had a lower death rate for the male population between the ages of 45-54 when compared with non-inspection states. "Moreover," the two investigators said, "two inspections appear to be more favorable than one."

The age range of 45-54 was selected by Drs. Buxbaum and Colton as it was the age range at which the most separation occurs between white and nonwhite death rates. The white death rate (male) at this point was 29 per 100,000; the nonwhite rate (male) was 48.1 per 100,000. Each rate refers to traffic fatalities, including pedestrian.

"The nonwhite population," said Dr. Buxbaum, "represented a group of persons with lower social and economic status than the white population. Our belief is that the higher risk of death from motor vehicle accidents may be related to the ownership of older and thus mechanically less safe vehicles. If this tendency toward death can be offset, one might expect to observe it in those areas in which motor vehicle

inspection takes place. Therefore, the hypothesis argues that nonwhites stand to gain proportionally more reduction in death rates from motor vehicle accidents than whites through inspection."

In other data gathered as a result of their study, Drs. Buxbaum and Colton, noted:

1. Death rates for both white and nonwhite groups tend to be higher in the Western United States.
2. A lowering of death rates was observed with a rise in income, especially in those states requiring inspection.
3. The more urban a state the lower its death rate.
4. The higher the population density of states the lower the death rate.
5. In the more densely car-populated states, death rates are higher.

6. There exists a correlation between changes of death rates and the adoption of state car inspection in the years between 1950 and 1960.

"For those states which had inspection prior to 1950," said the investigators, "a sizeable drop in nonwhite deaths for the study population took place, with a small drop in white deaths. In states which began inspection between 1950 and 1959, a drop representing about 10 per cent of the 1950 death rate occurred for both groups. And, in states which had not inspected in 1950 and had not begun by 1960, a rise in death rate equivalent to about 10 per cent for both groups occurred."

Both Drs. Buxbaum and Colton admit that their hypothesis is extremely complex, but they believe it is capable of solution.

## Beth Israel Hospital Dedicates New Building

The first phase in the Beth Israel Hospital's master development program has been completed. On April 3, 1966 the Rabb Building was formally dedicated in a ceremony that gave particular recognition to the family groups who have made service to the BIH a strong community tradition.

Highlighting the ceremony was the unveiling of the travertine plaque by Sidney R. Rabb which contains the names of the three generations of family members who participated in the gift to the Hospital. They are Sidney R. and Esther, Irving W. and Charlotte, Norman S. and Eleanor Rabb, of Boston, and Sidney L. and Jeannette Rabb Solomon of New York City. A younger generation of the Rabb family designated particular facilities within the building.

The Rabb Building is in a pivotal position in relation to other hospital buildings and will be the key link in a network of services surrounding inpatients and outpatients.

Major facilities within the 55,000 square foot building are a new diagnostic unit; centralized clinical laboratories in chemistry, hematology and bacteriology; a lecture hall and eight seminar rooms; a consolidated medical library; an enlarged blood bank, facilities for electrocardiography, phono and vector cardiography, and electroencephalography;

psychiatry treatment rooms; quarters for on-call house officers; an expanded and centralized admitting area which will become the central point of entry and departure for all patients; an ultramodern medical records department which will have readily available and complete records on all patients; a greatly enlarged emergency unit; and larger quarters for the rapidly growing physical medicine department.

## Joslin Award to Arky

The Elliott P. Joslin Research and Development Award has been given to Dr. Ronald D. Arky for the academic year, 1966-67. Dr. Arky is associate in medicine at Harvard Medical School, assistant director of the Diabetes Clinic at Boston City Hospital, and research associate in Harvard's Thorndike Memorial Laboratory at the Hospital. The Award will enable him to devote a major portion of his time to research on diabetic metabolism.

In 1965, working with Dr. Norbert Freinkel, assistant professor of medicine at Harvard and assisting physician at the Boston City Hospital, Dr. Arky demonstrated that insulin may directly regulate the intrahepatic packaging of circulation triglycerides and that an insulin-modulated heightening of glucogenesis may be operative in simple obesity.

## Computer to Provide Bibliographies for Countway Library

The Francis A. Countway Library of Medicine in the Harvard Medical Area has entered into an agreement with the National Library of Medicine, Bethesda, Md., to serve as a regional "Search Center" for receipt and dissemination of requested bibliographies of a medical or paramedical nature. The Harvard Center is one of five being established.

By using the facilities of the Harvard University Computing Center, the Countway Library will serve Maine, New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island. Organizations outside these States will be served only on referral by the National

Medical Library.

Mr. Ralph T. Esterquest, Librarian, said the program is part of the decentralized MEDLARS (Medical Literature Analysis and Retrieval System) of the National Library of Medicine. In Bethesda, MEDLARS is employed in the computer production of the monthly "Index Medicus," the National Library's comprehensive index of current medical periodicals. MEDLARS involves the use of digital computers and special composing equipment, GRACE (Graphic Arts Composing Equipment), which is capable of providing excellent typographic copy.

Magnetic tapes on which have been recorded the basic information used in the compilation of "Index Medicus" will be made available to the Countway Library, and will be housed and used at the Computing Center at Harvard. The periodical citations stored on this tape will be scanned by computer in response to requests for literature searches that come to the Library from practicing physicians and medical research scientists in the New England area. "Ultimately," said Mr. Esterquest, "we hope to be able to receive requests for bibliographic information before 5 P.M. and have it ready by 9 A.M. the following day."

### Aesculapian Room Dedicated

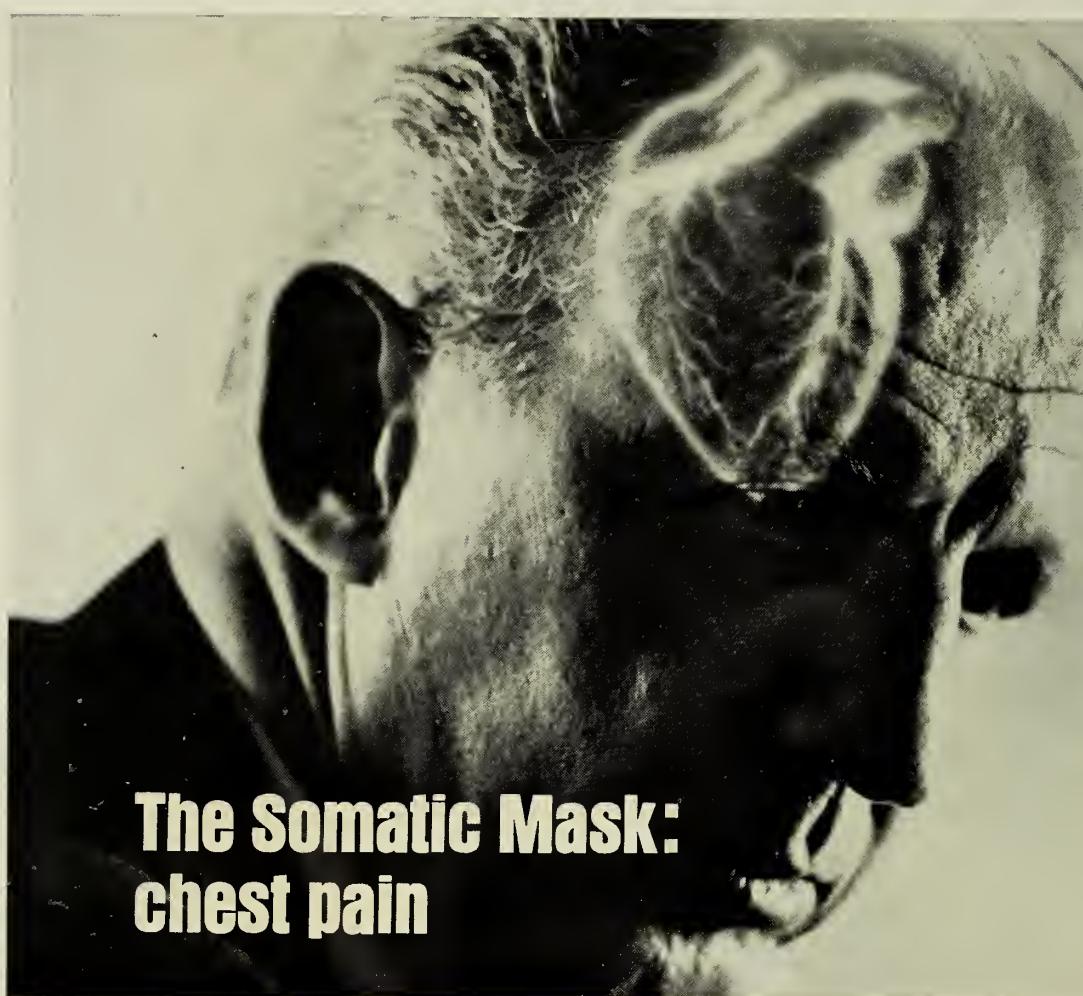
# THE AESCULAPIAN ROOM GENEROUS GIFTS FROM MEMBERS OF THE AESCULAPIAN CLUB AND FROM THE WIVES OF AESCULAPIUS MADE THIS ROOM POSSIBLE



A unique room was dedicated in the Countway Library of Medicine on April 26, 1966. The Aesculapian Room is the only one in the library which contains nothing medical—except its name. The books range from the *Encyclopedia of Opera* to *Cat on a Hot Tin Roof*. Participating in the ceremonies were: Curtis Prout '41, president of the Aesculapian Club; Richard P. Stetson '26, chairman of that part of the Program for Harvard Medicine that raised the funds for the room; Dean Robert H. Ebert; Mr. Ralph T. Esterquest, librarian; and John H. Finley, Eliot Professor of Greek Literature at Harvard College.

Harvard Medical Alumni Association  
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## The Somatic Mask: chest pain

### heart disease or psychic tension?

"Heart symptoms"—chest pain, tachycardia, arrhythmia—inevitably alarm and preoccupy the patient, though they may be completely without organic basis. Such symptoms often are somatic masks of psychic tension, arising from constant encounters with stressful situations.

When the problem is diagnosed as emotionally produced, consider Valium (diazepam) as adjunctive therapy. Valium (diazepam) acts rapidly to calm the patient, to reduce his psychic tension and relieve associated cardiovascular complaints.

NEUROTIC FATIGUE—the chronic tiredness resulting from emotional strain which so often accompanies psychogenic "heart" symptoms—also can be controlled by this highly useful agent. Valium (diazepam) often achieves results where other psychotherapeutic agents have failed.

Valium (diazepam) is generally well tolerated, and usually does not impair mental acuity or ability to function. If side effects such as ataxia and drowsiness occur, they usually disappear with dosage adjustment.

**In prescribing: Dosage**—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hrs, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. Geriatric patients: 1 or 2 mg/day initially, increase gradually as needed.

**Contraindications**: Infants, patients with history of convulsive disorders or glaucoma.

**Warning**: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

**Precautions**: Limit dosage to smallest effective amount in elderly patients (not more than 1 mg, one or two times daily) to preclude ataxia or oversedation. Advise patients against possibly hazardous procedures until correct maintenance dosage is established; driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. Warn patients of possible combined effects with alcohol. Safe use in pregnancy not established. Observe usual precautions in impaired renal or hepatic function and in patients who may be suicidal; periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

**Side Effects**: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances and hallucinations) and changes in EEG patterns. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

**Supplied**: Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 for convenience and economy in prescribing.

**Valium®(diazepam)**  
2-mg, 5-mg, 10-mg tablets

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Division of Hoffmann-La Roche Inc.  
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